

**An Investigation into the
Management of Clinical Incidents
Involving Qualified Nurses.**

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Declaration

This thesis is my own work and no part of it has been submitted for a degree at this or any other university.

Dedication

This thesis is dedicated to the memory of my grandmother, Mrs Christina Miller, her encouragement will stay with me forever.

Acknowledgements

This research involved a number of people and organisations and the following thanks are due:

My greatest thanks must be reserved for my family, Winnie, Hamish and Elise. The study could not have been completed without their unstinting love, support and understanding.

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Abstract

Background: The researcher's interest in the emerging areas of clinical governance and risk management within the National Health Service (NHS) was the genesis of this study. A growing concern about the apparent exponential rise in the number of untoward clinical incidents, the lack of studies of such incidents involving nurses and the developing interest in the apportionment of blame, were the basis of this research study examining the management of untoward clinical incidents involving qualified nurses.

Method: This qualitative study combined a number of different techniques to generate the data. An analysis of local and national policy documents with regard to the management of clinical incidents was undertaken. This was used to understand the framework within which the subject organisation was expected to manage such incidents. Fifty reported untoward clinical incidents were examined in detail using the available documentation. The qualified nurses involved were then approached to take part in individual semi-structured interviews, to elicit their views on the structure, process and outcome of the management of the incidents. In order to establish how Fatal Accident Inquiries (FAIs) contributed to the overall understanding of incidents resulting in death, forty-one inquiries from around Scotland were reviewed.

Conclusions: A number of conclusions were drawn from the data using these principle sources. Throughout the study the policy framework changed, reflecting the dynamic nature of this matter within the NHS.

- There was a perception among qualified nurses that senior nurses involved in the investigation of an incident sought to blame and punish a nurse for their role within an incident as opposed to reviewing systems and processes potentially contributing to an error. Nurses reported inconsistencies between different managers involved in the management of incidents. Nurses also drew comparisons between different approaches adopted for doctors, especially where both were involved in the same incident.
- Nurses attributed different approaches to different 'types' of nurse managers. It was evident that such punitive approaches prevented nurses from reporting incidents for

fear of the reprisals. Some nurses attempted to deflect blame away from themselves and to attribute it to organisational issues whilst others accepted blame as a result of their involvement in an incident

- A consistent finding was nurses reported a blame-free culture was neither realistic nor desirable but described a 'just and fair' culture as being more appropriate. Such a culture recognising that errors are part of everyday life and should be seen within this context whilst ensuring that patients remain protected by calling nurses to account for any actions which may be regarded as negligent.
- It was regularly reported that the lessons learned from such incidents were not disseminated either within the managerial units or across the organisation as a whole. Maintaining confidentiality in relation to the nurses involved was cited as the main reason for this lack of sharing.
- There is little evidence that the wider literature available in respect of error management has been incorporated into policy development. The pre-determined standards in relation to this area of corporate governance, although at an embryonic stage have attracted significant criticism.
- The determinations produced from Fatal Accident Inquiries (FAIs) highlight shortcomings and within systems and processes likely to have contributed to a death. Sheriffs' have used the determination to redress the balance of some of the very negative and unjustified reports in the media. There is little evidence that these determinations are used as learning opportunities.

The research presents a new model for the management of clinical incidents involving qualified nurses. This model is presented drawing on the findings of this research study as well as the outcome of other relevant sources. The RADAR model comprises of 5 stages; **R**ecording, **A**nalysis, **D**efining, **A**tttribution; **R**eaction.

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Part 1

Clinical Incidents in Context

Chapter I

SETTING THE SCENE

THE PERCEPTION

The popular press would have one believe that the number of untoward incidents within the NHS has risen exponentially over the past decade and is likely to continue to rise in the next. The nature of some incidents has certainly resulted in dramatic headlines. Such headlines have done nothing to reassure a worried public that the words of Florence Nightingale, when she declared that hospitals should do the patient no harm, ring true in the 21st century. A president of the Royal College of Physicians commenting on the press' handling of medical errors noted;

'There is rarely an informed comment on likelihood or cause, rather a tacit assumption that they should never happen – and an implicit conclusion that they are getting more common.' (Alberti 2001)

In the recent past, the perceived rise in the number of significant clinical incidents has resulted in what one author describes as: -

'The resurgence of a reactionary blame culture that many more idealistic souls had hoped was on the wane.' (Merrett 2001).

The data from NHS information systems are incomplete and obtaining accurate information with regard to the number of clinical incidents is problematic. It is therefore difficult to assess the degree to which this perception matches reality. What is clear is that there are some serious 'failures' within health care systems. This is aptly illustrated in the Department of Health for England, Wales and Northern Ireland document 'Organisation With A Memory' which notes that every year

- 400 people die or are seriously injured in adverse events involving medical devices.
- Nearly 10,000 people are reported to have experienced serious adverse reactions to drugs.

- Around 1,150 people who have been in recent contact with mental health services commit suicide.
- Nearly 28,000 written complaints are made about aspects of clinical treatment in hospitals
- The NHS pays out around £400 million a year in settlement of clinical negligence claims, and has a potential liability of around £2.4 billion for existing and expected claims.
- Hospital acquired infections – around 15% of which may be avoidable – are estimated to cost the NHS nearly £1 billion.

(Department of Health 2000)

PERCEPTION VS REALITY

Within the context of the Scottish Health Service, the number of medical negligence claims lodged with the Central Legal Office (CLO), which handles all claims for the NHS in Scotland, has not seen a dramatic change in the 3 years 1997-2000.

Table 1: Number of Claims in NHS Scotland 1997-2000

Year	Number of Claims
1997 – 98	520
1998 –99	524
1999 – 2000	482

The value of the claims over the same period demonstrates a significant rise.

Table 2: Value of Claims in NHS Scotland 1997-2000

Year	Value of Claims (£M)
1997 – 98	45.7
1998 –99	61.4
1999 – 2000	84.1

However, these figures must be interpreted with some caution. The actual amount of money paid out to claimants over the same period shows a reduction.

Table 3: Total Cost of Claims Paid in NHS Scotland 1997-2000

Year	Cost of Claims paid (£M)
1997 – 98	4.1
1998 –99	4.4
1999 – 2000	3.5

Medical negligence claims as defined by the CLO include claims against all clinical staff and are not restricted to doctors. These data are a poor proxy for untoward clinical incidents but they are the only centrally available data in relation to clinical incidents in Scotland.

In its first national overview of generic clinical governance standards, NHS Quality Improvement Scotland (NHS QIS) draw a number of conclusions, indicating that NHS organisations in Scotland and their staff have not made risk management a top priority. The report notes

- NHSScotland organisations are still reactive rather than proactive, responding to problems rather than anticipating and potentially avoiding them.
- Even where organisation-wide policies have been developed, they are not always visible at the locations where care is actually provided and are not always known and understood by staff and patients. Too often, there are still different policies on the same issue in place within one organisation.
- Learning and best practice are not easily shared between and across organisations.
- Communications, nationally and locally, are not always effective.
- Many NHSScotland organisations still do not manage potential risks to patients effectively.
- NHS staff are apprehensive about reporting concerns and risks.
- Staff shortages continue to raise patient care risks.

In summary

‘...very few parts of the service could demonstrate that they have implemented a common approach across the organisation and as expected, top ratings are an aspiration that has yet to be achieved.’
(NHS Quality Improvement Scotland 2003)

Patient care is a risky business. The complexities of the human interaction between healthcare professionals and their patients and the interfaces between different clinical professionals only add to the risk. Nurses who are the only the members of the multi-

disciplinary team to provide 24 hours bedside care are particularly affected by this phenomenon.

THE RESEARCH

The provision of healthcare, the nature of nursing as a profession and the general 'fascination' with blame generated the interest in the development of the hypothesis that incidents involving qualified nurses are likely to result in the apportionment of blame to an individual nurse. The aim of this research study is to investigate the processes through which Trust managers handle incidents involving qualified nurses, and how the outcome of these processes is used to inform risk management procedures within organisations. The key objectives of the study are:

- To describe the current processes employed within an organisation to record, report and investigate untoward clinical incidents.
- To examine the consistency in the application of these processes within an organisation and to identify the reasons for any inconsistent approaches by managers.
- To examine any differences in processes between two separate organisations within the National Health Service in Scotland in order to identify any fundamental difference between these organisations. (NB this particular objective is discussed in much greater detail in Chapter III).
- To describe the outcomes of investigations in relation to how the individual(s) under investigation are dealt with and how the results are used to inform changes in practice and risk management processes.
- To determine whether blame or fault is apportioned to an individual(s) and the relationship between the apportionment of blame and the eventual sanction against the individual(s).
- To examine the criteria used for referral to an external agency (e.g. further legal action) and explore what criteria are used to determine whether a Fatal Accident Inquiry is merited.

The aims and objectives of the study were developed from an initial exploration of several issues including the role played by nurses in clinical incidents, the application of the theory of risk management and the apportionment of blame.

NURSING AND CLINICAL INCIDENTS

Historically, there is a perception that the nursing profession has sought to punish the perpetrator of an error. The militaristic, hierarchical structures, which have been a feature of nursing management until the relatively recent past, may have resulted in nurses being punished for incidents that may have been outwith their control. Bassett (1998) presents the potential tensions between the needs of general management, the quality of patient care and the nursing profession, the implication of these comments is that the culture in the NHS (and more particularly within nursing) is so closely linked to tradition, hierarchy and bureaucracy that the introduction of a more business focussed culture has 'created a confusing and demanding dimension.'

'The conflicting elements within the nurse manager's roles have much to do with the origins of nursing, gender, social class and protective professional strategies deployed by nursing and medicine.' (Basset 1998)

Foundations of Nursing

"Nursing has its roots in the traditions of the Church and to a lesser extent the army; both traditions were strongly authoritarian and hierarchical and continued to influence nursing after it became a secular occupation." (Baly 1980)

The act of caring is as old as humanity itself. To whichever ideology of the origins and nature of human beings and their interactions is subscribed, there is a basic understanding that one human should care for another at times of vulnerability. Nursing as a profession has clear origins in military and religious settings. Able-Smith (1979) suggests that through such institutions, nursing has developed its language, rituals, uniform and body of traditions. The influence of religion on nurses and nursing is clearly evident in the history of its development. This can be demonstrated by the composition of the various

groups of nurses who joined Florence Nightingale in the Crimea. The first cohorts of women were drawn from Anglican orders, St John's House, Catholic convents, working women experienced in caring for the sick and Irish nuns. Indeed Florence Nightingale herself makes several references in her own diaries and other writings to undertaking God's work and records that God has spoken to her through 'voices'. (Baly 1991)

Gender and Nursing

The effect of the gender of nursing has been the subject of much debate amongst authors. Lumby (1991) identifies that the very name of nurse has its derivations in Greek – to nurture or nourish. This she argues is essentially a female activity. Lumby goes on to suggest that the increasing numbers of men entering nursing has contributed to 'its belated professionalisation.' Dingwall et al (1988) identify four different categories of what they describe as 'nurses before modern nursing'. These include: -

- Members of the sick person's household.
- Handywomen
- Private nurse
- Medical attendants (apothecaries, dressers, residents and clinical clerks.)

Typically the first three groups were women and the fourth was men.

Ford and Walsh (1994) argue that nurses lost their control of nursing following the introduction of general management. This new management model was perceived to have resulted in the further control of nurses (females) by accountants and business managers (male).

“Nurses have traditionally, been oppressed by virtue of being predominantly women in a patriarchal society and also by virtue of being seen as handmaidens to the powerful medical profession.” (Ford and Walsh 1994)

Ask any child to describe a nurse and they will inevitably tell you that she is a woman in a white dress with a hat. Many female doctors will describe that they have been mistaken

for a nurse at least once during their career. The requirements of a nurse were described in 1946 as :-

‘No woman should take up the profession of nursing unless she is prepared for hard work, constant subordination of her will and for continued self-denial... She must be trustworthy, conscientious and faithful in the smallest detail of duty. She must be observant and possess a real power of noting all details about her patient. She must be promptly obedient, and respect hospital etiquette.... A nurse’s manner to her patient should be dignified, friendly and gentle, but no terms of endearment should be used. She should surround herself with mystery for her patient and never discuss her own private affairs.’ (Probationer’s notes; St George’s Hospital 1946: in From Cradle to Grave)

Social Class and Nursing

Pre Florence Nightingale, most ‘nurses’ were from the lower social classes. One of her main influences was to introduce middle class ladies into the profession in an attempt to improve the standards. Dingwall et al (1988) reiterate a view presented almost three decades earlier that working class women carrying out nursing care has been ‘largely ignored by historians of the occupation.’ As a result the popular image has been developed through fictional works, for example, Dickens’, Mrs Gamp in Martin Chuzzlewit. Whilst it is acknowledged that such accounts are produced to achieve a particular view required by the author for his / her own ends these descriptions have some grounding in a grim reality, which often the author is trying to correct by illustrating the issue within their work. The social class of early nurses demonstrates the subordinate role played within a social structure.

‘At the beginning of the nineteenth century hospital nursing was done by mature women of the domestic servant class. Hardened by their experience of life, and often reinforced with gin, they were able to face the confusion and stench of the hospital wards.’ (Able Smith 1979)

Social class no longer dictates access to modern nursing, nor is it dependent on military or religious bodies for its recruits. The move from a vocational, apprenticeship style training to tertiary education has broadened the recruitment base. Those who were previously excluded from direct access are now exploring alternative routes.

Nursing and Management

Basset (1998) describes the conflicting elements of the various approaches adopted by different groups of managers. These are characterised by the scientific approach (the one traditionally adopted by the NHS) and the behavioural approach, summarised in table 4 below.

Table 4: Scientific Vs Behavioural Approaches to Management

Scientific Approach (Traditional NHS Approach)	Behavioural Approach
<ul style="list-style-type: none">• Staff need to be coerced, controlled and directed	<ul style="list-style-type: none">• Staff are committed, seek responsibility and care about their work
<ul style="list-style-type: none">• The needs of the individual are not important	<ul style="list-style-type: none">• The needs of the individual are important
<ul style="list-style-type: none">• The stick is better than the carrot	<ul style="list-style-type: none">• The carrot is better than the stick
<ul style="list-style-type: none">• A command and control approach is effective	<ul style="list-style-type: none">• A facilitative, participatory democratic and people centred approach is effective
<ul style="list-style-type: none">• The focus should be on individual fault and blame	<ul style="list-style-type: none">• The focus should be on system failure and not blaming the individual.

The social background, origins and gender aspects of nurses and nursing forms a picture of a female-dominated occupation, struggling to have itself recognised as a profession, dominated by, and seen to be subservient to, the medical profession, based on religious and militaristic regimes of obedience with its practice firmly rooted in rituals and routines. These are important aspects in the development of nurses and nursing practice and are vital in our understanding of how modern practice and management have developed. They are of particular relevance in understanding nursing's attitude towards the management of errors.

RISK

The identification and management of risk has been a key feature of industries for many years. More recently it has been a feature of both clinical and non-clinical aspects of management within the NHS. As the NHS developed during the 1980s and 1990s adopting more business-like approaches, the concept of risk became more prominent in the management of healthcare. For clinicians, balancing risks of different treatments or indeed whether to treat or not to treat has been an integral part of patient management, without necessarily having the label of clinical risk management.

As the concept of clinical governance developed from the 1997 White Paper, *Designed to Care*, the process of risk management was developed into a framework, designed to improve the entire patient process. In developing criteria for success the Scottish Executive Health Department included: -

‘Techniques such as risk management will be utilised to anticipate and minimise potential problems.’ (NHS in Scotland 1998)

The Clinical Negligence and Other Risk Indemnity Scheme (CNORIS) has been developed in the NHS across the UK in different forms to assist NHS organisations to develop risk management strategies to deal with both clinical and non-clinical risks. This combined with the standards developed by NHS Quality Improvement Scotland sets out a framework for quality improvement. These organisations argue for the need for a structure that assesses, manages and learns from clinical incidents.

Risk in Nursing and Other Sectors.

The approach to managing errors adopted by nurses traditionally has led to a number of unwelcome side effects including individuals becoming reluctant to admit when errors have been made. The reporting of errors and staff's reluctance to come forward with information about incidents and near misses has resulted in the information relating to untoward incidents being incomplete and patchy. A number of comparisons have been drawn between the health service and other industries, the most common comparison has been the airline industry where voluntary, anonymous reporting of errors and near misses

has resulted in a more open approach to the management of incidents, where lessons are learned and a culture of continuous improvement is fostered. Professor Liam Donaldson, comments that

‘The aviation and other industries have systematic approaches to analysing mistakes and failures and learning the lessons. The NHS needs to apply what is known from those sectors to its efforts to assure quality of services to patients.’

As clinical practitioners, nurses have used risk management techniques in delivering nursing care without necessarily recognising them as such. Therefore, risk management, as a concept is not new to nursing practice it is simply a new term for what has been an integral part of the assessment, planning, implementation and evaluation of nursing care. More recently these have been used extensively in very specific areas of care for example the risk associated with the moving and handling of a patient, infection control and levels of observation.

The most common errors involving qualified nurses are medication errors and these are explored in some detail within Chapter III. The causes of medication errors demonstrate the interactions between nurses and patients as well as the interdependency between doctors and nurses in ensuring that the correct patient receives the correct drug, at the correct time via the correct route. They also illustrate the range of skills and knowledge required to make certain that all of these elements come together to make sure that patients receive their prescribed therapies and to ensure that patients are not put at risk by either not receiving their treatment or receiving the wrong treatments.

WHO’S TO BLAME?

It appears that the first reaction in some quarters when an incident occurs is to find out who is to blame. This is not just the reaction from the affected patient and their family but it is also whipped up by the sensationalised headlines in the media and more worryingly within the professions and management. It would appear that as the BMJ put it that ‘blaming individuals is more emotionally satisfying than targeting institutions.’ Goodman

(2002) echoes this view in his review of a new textbook dealing with blame in medicine declares

‘I do know some people who should be forced to read Errors, Medicine and the Law: the ones who on learning of a self reported drug error suspend the doctor with the explanation that he wasn’t paid his salary not to read labels.’

The concept of blame is one that has exercised the minds of society in general and the media in particular and has been the subject of some comment.

‘Blame must surely rank among one of the most unpalatable and peculiar human devices, not least because it’s generally the weak and culpable who most often employ it.’ (Muriel Gray, Sunday Herald, 20th July 2003 p11).

‘The official inquiry into the sinking of the Marchioness riverboat has blamed the captains and owners of both vessels for the disaster (BBC News 23rd March 2001)

‘Rumsfelt escapes blame in ‘whitewash’ Abu Graib report’ (Telegraph Headline 15/08/04)

‘A babysitter accused of causing life threatening burns to a baby by holding her under the hot water tap took the blame for the child’s mother’ (BBC News 13/02/02).

‘Where to Place the Blame? Some blame violence in the media and even sue over it.’ (Tustin Amole 1999 – Rocky Mountain news 20/04/1999)

‘Peter Mandelson, Gerald Corbett, Bob Ayling – all have been labelled scapegoats. It seems the urge to shift blame is innate, but now there’s call for us [to] restrain this impulse.’ (BBC News Online 16/02/2001)

‘And our own society seems so hooked on blame and recrimination, which we sometimes dignify by the name of accountability. Accountability is important, but it can tip easily into a witch-hunt.’ (Alexander McCall Smith, The Herald Magazine, 16th August 2003 p10).

Chapter II

A REVIEW OF LITERATURE

In undertaking this literature review, a number of sources have been utilised. These include the electronic nursing, medical and law journal databases, university and NHS libraries, the researcher's personal library, media and personal communications. The review explores a number of different issues and is presented across six broad themes.

1. Professional nursing issues
2. The interface with the medical professions
3. The theory of errors
4. Organisational issues and lessons from other industries
5. The concept of blame
6. The legal context.

1. PROFESSIONAL NURSING ISSUES

[a] The Nature of Nursing

In order to understand the issues relating to current nursing practice there is a need to review the history of the nursing profession and how it has developed not only as a distinct profession but also as part of the multi-disciplinary team in which it functions. Inextricably linked with this exploration of nursing is a review of women in society and the patriarchal role-played by the medical profession in relation to nurses and nursing. Whilst there is a temptation to look at nursing solely in relation to women's issues, Mackintosh (1997) reminds us that for as long as records have been available, men have played a role in nursing. Therefore, whilst the changes within nursing are a reflection of the social change experienced by women, they are by no means either synonymous with, or exclusive to, women.

There is danger in undertaking an examination of the nursing profession in isolation. The interfaces with medicine and other healthcare professions are clear and examined later in more detail. The issues that have faced the nursing profession throughout its history are

not peculiar to the occupation. Abel-Smith (1979) draws a parallel with other professions that have undergone similar transformations; for example the relationships between certified and uncertified teachers and between qualified and unqualified social workers. Within the health services there are other tensions between different professions for example between ophthalmologists and opticians and dental surgeons and dentists. Abel-Smith goes on however to argue that the exceptional feature of nursing is the work. The close working with pain, suffering, death and dying cannot but fail to have an impact on those individuals who are exposed to this routinely as part of their normal working pattern.

‘The setting in which nurses work may well account for some of the features of the profession – the tendency to withdraw to the protective solidarity of a uniformed group, the search for perfectionism and the attempt to achieve it by discipline, and last but not least, the widespread public admiration for those who take on nursing work.’ (Abel-Smith 1979)

In particular the search for perfection through discipline is a feature of the nursing profession that is important in the examination of the management of clinical incidents. It could be argued that it is this striving to achieve perfection that has resulted in a culture whereby nurses not only punish themselves but also each other (in particular subordinates) when something does not meet some amorphous notion of perfection. Similarly this may account for why medical staff who have perhaps been more realistic about its limitations, accept that medicine and healthcare are not exact sciences and therefore things will go wrong. This was well illustrated by a neurosurgeon who subsequently became the Minister for Health for Scotland who commented to the Chief Nurse for Scotland that only a nurse would expect another nurse to know everything at the point of qualification. (Personal Communication)

Maggs (1996) argues that in research terms

‘The history of nursing largely concentrates itself with organizational issues- battles for registration, movement towards professional status – or with the nurses themselves – education and training for example.’

This needs to be expanded slightly for the purposes of this research in order to review the social and philosophical issues that have resulted in nursing as a profession evolving to the stage at which it currently finds itself. Abel Smith (1979) and Baly (1980) both presented their histories of nursing within the social context. Abel Smith identifies how the development of nursing reflects the position held by women in society. The fight for registration, recognition as a profession and as a result the right to self-regulation was a long fought battle. The issues relating to professional self-regulation will be examined further later in the review. Following the registration in 1919 he observes

‘The fact that most of the duties performed by the nurses looked to the casual observer so close to those performed by the housewife in her daily round may have led to an exaggerated attempt to differentiate the work and expand the duration and content of the training syllabus.’

Marshall & Wall (1999) illustrate that whilst the role of women in the 19th century was portrayed as a subservient role to men and restricted to domesticity...

‘...in the pluralistic West a variety of organised religious women built and administered hospitals, initiated professional nursing and provided effective health care services.’

The origin of nursing has shaped the practice and management of nurses and nursing. Abel-Smith (1960) notes;

‘The profession developed its language, its ritual and its uniform – its own body of traditions which were drawn from the army, from religious orders and possibly the new girls’ public schools.’

This observation is reiterated by Bassett (1998) who, in describing differing management approaches within the NHS, illustrates that the punitive approach adopted by some managers is one..

‘...rooted in the religious, military and bureaucratic origins of nursing and the health service.’

The hierarchical nature of the nursing professions has been widely recognised and discussed and there is a perception that this has had a diminishing role over recent years. However, Begley (2002) argues that within midwifery, hierarchy is still very much alive and noted that this was less evident in other healthcare professions. This study also reported that students perceived a lack of caring from their more senior colleagues. Within the study Begley cites a number of other authors who outline similar conclusions (Melia 1981, Treacy 1987 and Hanson 1996). Whilst this study did not deal specifically with the management of errors it illustrates that the organisational culture remains hierarchical and this in turn leads to some of the difficulties around adopting a more open organisational culture.

In the early 1990s there was considerable debate within the nursing professions around role extension and the development of skills previously the exclusive domain of medical staff. The then governing body for nurses midwives and health visitors produced the Scope of Professional Practice (UKCC 1992), detailing the framework within which such roles could be undertaken safely. One of the major areas of practice this related to was intravenous therapy. Scales (1996) outlines the roles and responsibilities with regard to intravenous therapies although the issues of accountability and responsibility apply equally to all areas of nursing practice.

In modern day clinical practice Gough (2000) argues that the power base within the NHS is beginning to shift in favour of nursing. She points to the development of NHS Direct (NHS 24 is the equivalent organisation within Scotland) as nurses not merely becoming the gatekeepers of healthcare but pioneering a new model of healthcare delivery. It is fair to say that some of the analyses (usually anecdotal and usually from doctors) would not necessarily agree with this appraisal of NHS Direct. Similarly some organisations would argue that this development has achieved little other than attracting the most experienced staff out of acute areas at a time of national shortage. Gough points to other developments, which she argues have resulted in new opportunities for the development

of nursing as a profession. These include, the development of nurse consultant roles, the creation of modern matrons and the development of nurse led intermediate care.

In a later paper Gough (2001) develops the theme of the opportunities open to nursing and argues that one of the main barriers to the profession grasping the opportunities is the apparent need to maintain the rigid notions of a profession. She quotes Professor Davies as identifying the characteristic of an 'old' profession as elitism, paternalism, authoritarianism, having mastery of knowledge (highly gate-kept and accessible to no-one else), control, aloofness, detachment and distance. She then goes on to argue

'Best nursing practice is characterised not by paternalism but by partnership; not by authoritarianism, but by collegiality and collaboration; not by a mastery of knowledge but by shared and borrowed knowledge and by reflective practice and life-long learning; not by aloofness and detachment but by engagement and the therapeutic use of self, not by control but by empowerment of self and others.'

It is clear that many of these issues are pertinent to the management of clinical incidents and how the management under old professional styles can be improved through those characteristics of the new professional approaches described by Gough. This is not to conclude that hierarchies are in themselves wrong. It is however clear that the abuse of power bases, which hierarchy can be guilty of encouraging, has led to the inappropriate and arguably unfair, management of clinical incidents.

[b] Nursing Misconduct

A potential proxy measure of nurses' involvement in clinical incidents is the level of misconduct hearings undertaken by the statutory body. Allegations of misconduct are reported to the nurses' governing body. The name of the governing body has changed from the General Nursing Council to the United Kingdom Central Council for Nursing Midwifery and Health Visiting and most recently to the Nursing and Midwifery Council from June 2002. The sources of complaints of misconduct come from three main areas; employers, the public, and police who are obliged to report to the statutory body any criminal offence committed by a nurse midwife or health visitor. There has been a

progressive rise in the number of complaints made. The number and source of complaints are outlined in tables 5 and 6 (UKCC 2001).

Table 5: The number of Complaints made to Nurses' Governing Body 1996 - 2001

1996-97	1997-98	1998-1999	1999-2000	2000-2001
893	1032	1077	1142	1240

Table 6: The source of complaints made to the Nurses' Governing Body, 1996 - 2001

Source	1999-2000		2000-2001	
	No	%	No	%
Employers	539	47.2	592	47.7
Public	249	21.8	276	22.3
Police	250	21.9	230	18.5
Miscellaneous	104	9.1	142	11.5
Total	1142	100	1240	100

The number of allegations between the two time periods has changed but the proportion by source is similar. The categories of misconduct have not changed significantly across time. The largest category in 2000/2001 was physical or verbal abuse of patients, which accounted for 28.5% of cases with 30% and 31% respectively for the two previous years. In 2000/2001, failing to keep accurate records or failure to report incidents was the next largest category at 8.7%, which was slightly higher than the 6% the previous year. Whilst the governing body acknowledges there does not exist a list of offences that will lead to automatic removal from the register, it advises managers that the types of misconduct potentially leading to removal include, physical or verbally abusing patients, stealing from patients, failing to care for patients properly, failing to keep proper records and committing criminal offences.

A study undertaken in the United States of America (Croke 2003) examined in excess of 250 cases of negligence, lawsuits against nurses as well as complaints where the significant issue raised was the quality of nursing care. The findings were categorised into six major areas.

1. Failure to follow standards
2. Failure to use equipment in a responsible manner
3. Failure to communicate
4. Failure to document
5. Failure to assess and monitor
6. Failure to act as a patient advocate

The litigious nature of the culture within North America makes direct comparisons between there and the UK difficult. However the failings listed within Croke's study are similar to those complaints against nurses experienced within the United Kingdom. There are no data relating to the level of litigation against nurses specifically and therefore it is difficult to make reasonable comparisons between the two systems. There have been a number of high profile cases relating to criminal activities involving nurses. These in the main have related to nurses murdering or attempting to murder patients in their care.

[c] Nursing Leadership

The nature of nursing leadership has changed dramatically over the past years and it is a valid area of enquiry to establish whether these changes in nursing leadership have had any influence over the management of errors. Nursing has a pivotal role in delivering safe healthcare as well as ensuring that the environment in which healthcare is provided is also safe. Mitchell (2002) argues that nurses are considered to be at the sharp end of delivering care where errors occur as well as where they can be prevented and mitigated. Nurses are also at the 'blunt end' of designing, managing and analysing systems. The conclusion drawn by Mitchell is that nurses are in a key position to improve the delivery of safe patient care but tend not to be included in designing the systems in which they function. She illustrates this further by quoting Lewis Thomas, a physician-scientist who noted

‘the institution is held together, glued together, enabled to function as an organism, by the nurses and no-one else.’

Some two years earlier Henry (2000) outlined the same issues around nurses’ influence on the quality of healthcare delivery and identifies a number of reasons for this;

- Nurse comprise the largest component of the healthcare workforce
- Nurses are heavily involved in the delivery of healthcare
- Nurses are heavily involved with the professional management
- Nurses are accountable for much of the care provided in many countries and for the design of health systems, through which care is delivered, quality is assured and errors are avoided.

Henry also argues that nurse leaders have effectively ignored the evidence available in relation to the management of errors. The commentary from Henry points to the work undertaken by Leape suggesting that systems rather than individuals should be the focus for any investigation.

‘Expert evidence and the efforts of thoughtful researchers show us that instead of blaming nurses and doctors, instead of pointing the finger and alleging misconduct, we must understand to a much greater degree than we do presently, the basics of health systems so that we can more easily identify then eliminate problems with organization design and maintenance...Nurse managers must be trained in the basics of system functioning and maintenance.’ (Henry 2000)

In an examination of leadership within the NHS Alimo-Metcalfe & Alban-Metcalfe (2000) describe the leadership qualities required within the organisation if the modernisation of the NHS so desired by politicians is to be achieved, and argue:

‘This is a key consideration for the NHS centre, since the government’s modernisation agenda will not be achieved unless the NHS recognises that cultures of blame, authoritarianism, narrow-mindedness and reckless disregard for staff are not to be tolerated.’

Whilst these observations were not made specifically in relation to nursing they are very appropriate and applicable to leadership styles within the profession.

[d] Summary

From the literature reviewed it is clear that the origins and evolution of nursing as a profession are key factors in understanding the approach it has taken to managing untoward clinical incidents. This part of the review has demonstrated the ways in which the origins and evolution of nursing have influenced modern nursing practice. Throughout the research the impact of some of these issues will be demonstrated through the observations made both by the researcher and by the participants during the interviews. Whilst the researcher accepts that the hierarchical structures within nursing have flattened, the effect of taller hierarchical structures remains. This is not to suggest that this is 'wrong' or that such structures do not have tangible benefits. However, where such structures are used to impose an unquestioning approach to management, the outcome can be a very negative one for individuals who have to function within such an environment.

Webster and Anderson (2002) assert: "...in nursing, blame remains the predominant approach for dealing with error." The literature relating to untoward clinical incidents involving nurses in the main deals with medication errors and this area is explored later. In drawing these two areas together, Osborne et al 1999 observe

"Nurses involved in committing a medication error may be reluctant to report it unless there is obvious harm to the patient. The reluctance comes from fear of punishment..."

It is also important to explore the inter-relationship between nursing and medicine, to understand further the complexities of why these two professions who work so closely together in the same environment have such different approaches to the issues of incident management.

2. THE INTERFACE WITH THE MEDICAL PROFESSIONS

Ootim (2002) discusses the issues of errors in relation to effective leadership within the NHS and identifies that as part of literature review undertaken it was clear that the volume of literature in relation to errors in medicine was significantly greater than that available in relation to nursing. The wider literature relating to errors within medicine is outwith the scope of this review however a truncated exploration of common issues and areas within medicine that are pertinent to nursing has been undertaken and presented.

[a] The Different Approach of Nurses and Doctors

It is well recognised – although there is little in the way of objective evidence to substantiate any claim - that whilst doctors ‘get away with’ errors as the old boy network tends to defend its own, nurses on the other hand are only too happy to see their colleagues dragged through a humiliating process of investigation, disciplining and even dismissal. Kellet (1996) illustrates this through a case where a consultant and a nurse were involved in the same incident. He identifies how at the end of the process the nurse was disciplined to a level only just short of dismissal and the consultant was able to practice as normal. To the objective outsider this seems iniquitous – but this would be a very simplistic conclusion and not one that acknowledges a number of different factors. These include the different roles and responsibilities of two different disciplines working within the same multi-disciplinary team, the different codes of conduct relating to each profession and the different historical evolutions of the individual professions. One question it does raise, however, is whether ‘natural justice’ has been done and been seen to be done.

Harding – Price (1999) attempts to illustrate the differences between the way doctors and nurses are treated by their regulatory bodies through the case of a doctor who ‘ordered’ nurses to withhold food supplements from an 85-year old lady in their care. He goes on to condemn the General Medical Council for not removing the doctor’s right to practice but chooses instead to suspend him for 6-months. He then goes on to argue

‘If nurses are struck off for misconduct then the same rules must be applied to doctors and other healthcare professionals.’

There is no indication in this manuscript to suggest that the nurses involved were struck off as a result of the same incident and therefore it is perhaps difficult to draw meaningful comparisons between how two different groups of staff are dealt with as a result of this particular incident. Given that different healthcare staff groups have different codes of conduct it could also be argued that what constitutes ‘gross misconduct’ may also be different. Whilst that may be the case, codes of conduct tend to be based on similar ethical and moral principles and therefore one would expect (and perhaps especially the general public expects) that what constitutes gross professional misconduct within different professional groups, is a breach of such similar principles.

Wu (2000) acknowledges that patients are of course the ‘first and obvious’ victims of any untoward clinical incident, but then goes on to argue that doctors are deeply affected by the same errors and that they could reasonably be regarded as the second victim. However, he later goes on to identify that other healthcare professionals are also affected and recognises that the different management systems within NHS organisations result in differences in how they are treated and how they react.

‘Nurses, pharmacists, and other members of the healthcare team are also susceptible to error and vulnerable to its fallout. Given the hospital hierarchy, they have less latitude to deal with their mistakes; they often bear silent witness to mistakes and agonise over conflicting loyalties to patients, institutions and team. They too are victims.’

Di Bisclegie (2002) makes a number of observations in relation to doctors and errors. He suggests that all doctors make errors, they are generally minor and that they become less frequent as the doctor’s experience becomes more extensive. The author then outlines three options open to any doctor when an error occurs. The three options are described as

‘Firstly, mistakes may be dismissed or blamed on others. This is clearly the path to more mistakes. Next mistakes may be dwelled upon and over

analysed so as to result in paralysis of the doctor. Most of us choose the third option, which is to analyse the mistake, learn from it and move on.'

This author presents what at first sight may be regarded as a very simplistic view of errors. It certainly demonstrates that the organisation in which this doctor functions may be completely unaware of errors committed by this individual doctor and therefore not only has an inaccurate view of the level of untoward clinical incidents but arguably has a 'dangerous' doctor functioning in the organisation. Whilst Di Bisclegie argues that doctors learn and move on, the wider organisation does not have the opportunity to learn from the errors. The author acknowledges that errors can be rationalised but they are nonetheless still mistakes. It could be argued that a doctor's ability to rationalise an error (the article would suggest that such rationalisation is by the individual doctor rather than to a colleague or management of the organisation) does not offer any level of assurance that the individual has learned from the error before moving on – potentially to make the same mistake on a different patient. Hettiaratchy (2001) takes quite a different approach and acknowledges that having made a mistake themselves they are less likely to be critical of others who have also made mistakes. This author also illustrates through the description of the error they were involved in that there are not always extenuating circumstances or they were part of a 'chain of error', but that sometimes people do get things wrong and goes on to argue:

'Perhaps if we were all slower to blame and quicker to understand, it might be possible to learn from our collective errors rather than consigning them to the bin marked "only happens to others"'.

The adage of prevention is better than cure arguably applies to errors as much as any other aspect of life. Lester and Tritter (2001) argue that one way of potentially reducing medical errors is to alter the way doctors think about errors through medical education and 'professional socialisation'. They identify a number of additions to the curriculum to assist in achieving what they acknowledge would be a 'longitudinal' approach and includes, team working, communication skills, evidence based practice and strategies for managing uncertainty. Such issues would also apply to nurses although these areas are already included within the current nurse education programme. The one method that

could improve this for both professional groups would be to undertake such undergraduate training together. The issue of collaborative education between the professions has been debated for some time. This has been in the main around the need to develop a multi-disciplinary approach from an early stage. Such joint education would have a number of other added benefits for professional practice including incident management.

[b] Incidents Involving Doctors

The number and nature of medical incidents is a constant source of material for the media and in particular it has provided the basis for some very lurid headlines for the tabloid press. Alberti (2002) commented on the lack of the discussion around the causes and likelihood of something going wrong and the apparent assumption that not only should errors never happen within healthcare settings but that the number is rising. He goes on to conclude that there are two important issues around the actual position, on the one hand errors have always happened and on the other we have no idea how common they are within the United Kingdom.

In 1996 one surgeon who was dubbed 'Dr Dolittle' by a tabloid newspaper following the tragic death of a patient, took matters further and successfully sued the newspaper for libel and was awarded £625,000. During the trial it was recognised that the doctors involved in the case were not at fault and that the newspaper was therefore libellous. However, subsequent cases have not deterred editors from such headlines. (Seldon 1996)

The intrathecal injection of the cytotoxic chemotherapy agent Vincristine was one such case. Dyer (2001) reports the same mistake occurred on thirteen different occasions in the UK in the previous sixteen years. Ten of these have resulted in death and the remaining three resulted in paralysis. Dyer goes on to describe one of the cases; that of a 12 year old boy who died as a result of an incorrect intrathecal injection, where the Crown Prosecution service dropped the charges against the two doctors involved, concluding that the child's death was a result of

‘chance events and failings at the hospital rather than gross negligence by the doctors.’

The prevention of cytotoxic disasters is proposed through some very simple strategies by a number of authors. For example, Crotty (2000), Fernandez (2000) suggest a number of solutions to deal with this problem

[c] The Extent of Medical Errors

There have been a variety of attempts to quantify the extent of medical errors and their impact. The most comprehensive review within the United States of America was undertaken in the late 1980s by Brennan et al (1991). This study is now regarded as the benchmark for estimating medical errors within a hospital. Using the methodology set out in the study from Harvard, Wilson et al (1995) was able to estimate the level of error within Australian healthcare system. Within the United Kingdom there have been few attempts to replicate the study to identify the incidence of errors within United Kingdom hospitals.

The National Patient Safety Agency (2002) undertook an exercise to quantify the level of errors in English hospitals through a system of anonymous reporting of errors by a small number of Trusts. The results caused a storm in the British press as the conclusions, if extrapolated across the NHS in England, would suggest approximately 850,000 incidents each year (BBC 2002). However, the study was recognised as being so flawed that the results should be reviewed with a great deal of caution. It prompted the Chief Medical Officer to host a press conference when it was thought there was a move to suppress the results. The entire system appeared to be flawed and therefore questions were raised about the validity of the exercise. The methodology was unclear, there were inconsistencies with definitions leading to under and over reporting in different hospitals, incomplete coding, and problems with the computer interfaces. Of the 27,000 incidents reported over a six month period 56% were unspecified and 59% were un-coded, large numbers of fields were missing, large amounts of data were unusable and only 1 in 20 Trusts were involved in the pilot.

One of the major issues surrounding the analysis (in particular the measurement) of untoward clinical incidents is obtaining a consensus opinion on the definition. In various studies there have been attempts to quantify the problem,

Table 7: A Comparison of incidents in Different Countries.

Country	Number and Outcome
USA	44-98,000 deaths
Australia	250,000 adverse events 50,000 permanent disabilities 10,000 deaths
Denmark	9% of admissions
New Zealand	10% of admissions
UK	850,000 adverse events / deaths / permanent disability

(NPSA 2002)

Vincent et al (2001) reported that the ‘epidemiology of adverse events has not been studied in Britain.’ Through a retrospective review of case notes Professor Vincent and his team attempted to quantify adverse incidents in two London hospitals, and concluded that the findings strongly supported the notion that adverse events in British hospitals were as serious a problem as in the USA and Australia.

[d] Professional Regulation

One of the defining criteria of a profession is self-regulation. Such self-regulation if not seen to deal with its professionals in an ‘acceptable’ way may result in pressure being placed upon government to replace the system with a different method, which takes away the profession’s ability to regulate itself. This applies equally to nursing as it does to medicine.

‘Historically, in the United Kingdom self-governance of the nursing profession has been accepted as a right. Yet it is important to remember that the prime reason for the existence of self-governing bodies is to

protect the public from disreputable professional practitioners and not to provide a 'cosy' system for regulation of practitioners by practitioners.' (Watkins 1999)

The aftermath of the Kennedy Report into the paediatric surgery issues in Bristol raised a number of questions with regard to the self-regulation of the medical profession and a growing dissatisfaction among the general public at what was seen as closing of ranks within a profession to protect a non-performing member. Gough (2001) argues

'there is now a growing loss of trust and confidence by the public in health professions to provide safe and effective care.'

[e] The Role and Function of the Regulatory Bodies.

Medicine's regulatory body, the General Medical Council, has acknowledged the apparent lack of trust in the medical profession and, in an attempt to regain some of the lost trust initiated a public campaign. (The Herald 6th April 2004). The head of GMC Scotland said; -

'We all recognise that there is enormous public confidence in individual doctors. This has been shown again and again, but it has equally been shown that there is some lack of public confidence in some areas. The road shows will look at increasing understanding of how medical education fits through to how doctors work in their professional life, and what happens if that goes wrong. For all of us when we understand how something works, it gives us greater confidence in it'.

The effectiveness of such a campaign remains to be proven. It is interesting to note that in the same report it was recognised that Scottish patients lodge proportionately fewer complaints with the GMC than patients in the rest of the United Kingdom. There does not appear to be a similar lack of confidence in the governing body for nurses and there is no similar public awareness campaign for the Nursing and Midwifery Council. It is suggested that there are two principal reasons for this.

- Firstly, there are within the medical profession a number of very high profile cases regarded as having been poorly handled by the GMC, the most notable of which was the case of Dr Harold Shipman, a General Practitioner who was

convicted of a number of murders and was thought to be responsible for the deaths of in excess of a further 200 patients within his care. It is reported that the Council disciplined him after he was convicted of drug and forgery offences in 1976 thought to be two years after his first killing. There have been a number of instances where cases were perceived to have been dealt with poorly by the UKCC (predecessor to the NMC) but they were neither as severe nor as high profile as the Shipman murders.

- Secondly, it is clear that the nursing regulatory body has been more willing to be seen to deal with cases of misconduct brought before its disciplinary committees. It could be argued that this is either a reflection of, or is reflected in, local systems of dealing with nursing misconduct where nursing is viewed as being very harsh against its own profession.

[f] Summary

Nurses and doctors interact as part of a multidisciplinary team on a daily basis. The totality of the care they deliver to patients is the result of a complex interaction based on mutual understanding and respect for their respective roles. They function within the same risk-laden environment, which, coupled with the intricate personal interactions evident in the therapeutic relationships with patients, results in the inevitability of an error occurring. All of this happens within a complex organisation, yet the literature available suggests that the approaches to dealing with untoward clinical incidents – even when both are involved in the same incident – appears to be very different between the two professions. It is evident the way in which the two professions deal with clinical incidents and their consequences are different. It is also clear that the two professions have different histories and socialisation processes. A corollary of such differences is separate ethical frameworks for each profession, which make it unsurprising that they have different approaches to managing similar situations. There are significant opportunities for these two professional groups to collaborate more effectively at undergraduate, post-graduate and everyday clinical practice levels to improve collective

understanding of the processes around error management and to reduce the likelihood of recurrence.

3. THE THEORY OF ERRORS

There are a number of authors who have written extensively on errors perhaps the most prolific and prestigious of this group of authors is James Reason. He has produced two seminal texts, *Human Error* and *Managing the Risks of Organisational Accidents*, which are widely quoted by other writers on, and researchers into, the subject of error management. These two particular texts provide a definitive view of the theory relating to errors and have been built upon by other authors in advancing a clearer understanding of antecedents to errors and the ways errors can be managed within a system that has mutual benefits for individuals affected by errors, and organisations in which they occur.

[a] Definitions

It is important to define exactly what is meant by error. A number of terms are used throughout the literature, within the media and as part of policy documentation, without a clear understanding of what is actually meant. Some of the terms are indeed used synonymously, which in strict terms is incorrect. As a result, estimates of the number of clinical incidents vary widely. This lack of clarity in defining an untoward clinical incident was one of the major criticisms levelled at a report produced by the National Patient Safety Agency. The lack of a definition that is interpreted consistently between the organisations involved meant that some reported all incidents; others only reported those causing harm or death to a patient. This resulted in a reporting system not being able to establish a clear understanding of the quality and type of incident.

The terms untoward incident, adverse event, accident, error and mistake all tend to be used synonymously. In a review of the literature Walshe (2000) identifies a number of different definitions used:

- ‘Any response to medical care in the hospital that is unintended, undesirable and harmful to the patients. (McLamb & Huntly 1967)

- A potential compensable event is a disability caused by healthcare management. (Mills 1978)
- Adverse patient occurrences (APOs)... refer to untoward patient events, which under optimal conditions are not a natural occurrence of the patient's disease or treatment. The common thread of all APOs is that they are events which health professionals agree are not desirable outcomes of medical management. (Craddick & Bader 1983)
- An unintended injury caused by medical management rather than by the disease process. The injury is sufficiently serious to lead to prolongation of hospitalisation or temporary or permanent impairment or disability in the patient. (Harvard Medical Practice Study 1990)
- An unintended injury or complication, which results in disability, death or prolonged hospital stay and is caused by healthcare management. (Wilson et al 1995)
- An untoward or undesirable occurrence in the healthcare process, which has or potentially has some negative impact on a patient or patients and results or may result from some part of the healthcare process. (Walshe 1998)

The terminology used within the management of untoward incidents itself colours the perception of the severity of the problem. Lorimer (1996) argues

‘ The word accident often obstructs the study of injury prevention. The word suggests an event that takes place without foresight or expectations, yet such events as a group are not random and do not occur by chance; they can be expected to happen, even if the time, place and precise circumstances cannot be foreseen.’

Miller (2001) develops this theme further by illustrating that the sinking of RMS Titanic was a result of a number of different factors, which were only relevant when the ship eventually struck an iceberg in the mid-Atlantic. The eventual sinking of the ‘unsinkable ship’ was caused not merely by the collision with an iceberg but a multitude of factors which as single entities may not have been important however when they came together at the time of the collision they all contributed to the eventual demise of the ship and the majority of its passengers. Miller goes on to draw some interesting parallels between these factors and those evident within the NHS. For example the appropriate skills and training of staff, the need for clear systems of working, the need for clear instructions that are accessible (both in terms of physical and language accessibility) and a sense of

invincibility (Titanic was thought of as being unsinkable and many clinicians have a view of 'this could never happen to me')

The two terms that need to be clearly differentiated are error and violation. Reason offers definitions for both of these terms, which Merry and McCall Smith develop a little further in order to enhance the understanding of these terms and how they are used.

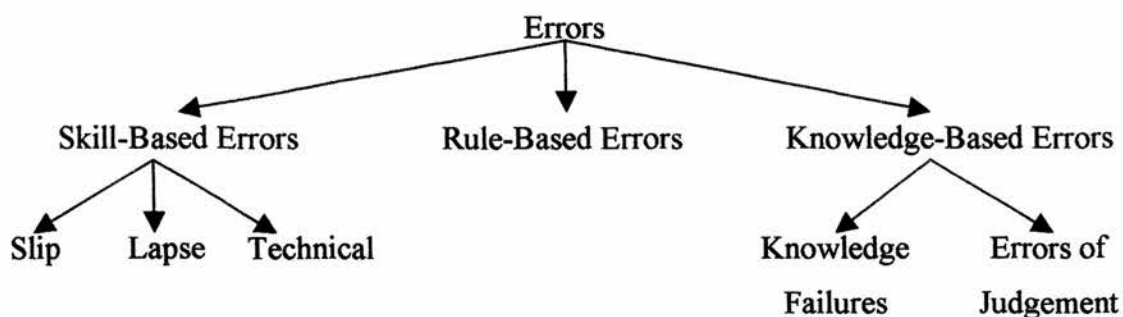
Error All those occasions in which a planned sequence of mental or physical activities fails to achieve its intentional outcome and when these failures cannot be attributed to the intervention of some chance agency. (Reason)

An error is an unintentional failure in the formulation of a plan by which it is intended to achieve a goal or an unintentional departure of a sequence of mental or physical activities from the sequence planned, except when such a departure is due to a chance intervention. (Merry& McCall Smith)

Violations Deliberate – but not necessarily reprehensible - deviations from those practices deemed necessary (by designers, managers and regulatory agencies) to maintain the safe operation of a potentially hazardous system. Deviations from safe operating procedures, standards or rules. (Reason)

A deliberate – but not necessarily reprehensible – deviation from those practices appreciated by the individual as being required by regulation or necessary or advisable to achieve the appropriate objective while maintaining the safety of people and equipment and the ongoing operation of a device or system.

To differentiate these two concepts simply Merry and McCall Smith suggest that errors are involuntary and violations are voluntary. The important difference between these two concepts in the management of untoward incidents will be examined in some detail later in the review. In exploring the writing of these important authors it is possible to define and adopt taxonomy of errors. Errors can be divided into three main areas, which can then be further sub-divided. Merry and McCall Smith expand on Reason's earlier work on errors, by introducing how the concept of blame can be viewed within the management of errors as Reason's texts on errors did not deal with blame.



Skill-based errors

Skill-based errors involve actions and are usually the result of distraction and can be subdivided into: -

- **Slips** - something is done which was not intended as a result of a failure of attention. An act of commission. For example a nurse gives a drug to the wrong patient as a result of being distracted during a medication round.
- **Lapse** - something is not done which was intended as a result of a failure of attention. An act of omission. A nurse does not administer a dispensed medicine to a patient having been called away to attend to another distressed patient.
- **Technical** - a skill-based error, which is distinct from a slip or a lapse. There are two main factors, which relate technical skill-based errors in medicine (1) patient variability (2) practitioner variability. Practitioner variability can relate to difference between two different practitioners or related to one practitioner but in different circumstances.

Rule-based errors

These are failures in either problem solving or planning.

- **Rule-based errors:** A failure in the process by which a set of circumstances is recognised and an appropriate rule applied. Either due to pattern of events is incorrectly recognised and matched to an inappropriate rule. Or due to the application of a wrong or inadequate rule to correctly matched mental schema.

Knowledge based errors or Deliberation Errors

These are deficiencies that lie in the knowledge stored in the memory or in the knowledge available from the events and circumstances of the situation.

- **Knowledge failures:** Those situations where the fault lies with the information recalled from the individual's internal store of knowledge. This may be due to either a failure of memory or the individual did not have the knowledge.
- **Errors of Judgement:** The decision may have produced the desired goal but didn't. The outcome is a poor guide of quality of decision. The decision should be called an error only if unsound for example if there is a fault in logic or a deficiency in the information.

Thompson and Dowding (2004) apply the theories proposed by Reason to nurses' clinical decision-making skills and conclude

'...that when making decisions nurses, like all people, are subject to uncertainty, error and heuristic short cuts. Unfortunately, it [the paper] has shown that these heuristics are fallible and can introduce unhelpful bias into decision-making. The need to prevent harm to patients demands that professionals learn from mistakes and take corrective action.'

[b] The Nature of Errors

The most common errors associated within qualified nurses are medication errors. In 1992 the UKCC identified that nurses who were involved in medication errors were often dealt with through the disciplinary processes within organisations. This in turn was likely to discourage the reporting of such incidents which, they comment, will be to the potential detriment of patients and of standards.

The reporting of errors is an area of considerable debate. The main question is whether any reporting scheme is either voluntary or mandatory. Cohen (2000) briefly outlines the relative benefits of both methods before coming down in favour of voluntary, reflecting the conclusion of the Institute for Safe Medication Practices.

The report by the Department of Health 'An Organisation with a Memory' (2000) presents some important figures of adverse events in the NHS.

- 400 people die or are seriously injured in adverse events involving medical devices.
- Nearly 10,000 people are reported to have experienced serious adverse reactions to drugs.
- Around 1,150 people who have been in recent contact with mental health services commit suicide
- Nearly 28,000 written complaints are made about aspects of clinical treatment in hospitals.
- The NHS pays out around £400 million a year settlement of clinical negligence claims and has a potential liability of around £2.4 billion for existing and expected claims.
- Hospital acquired infections – around 15% of which maybe avoidable are estimated to cost the NHS nearly £1 billion.

As has been demonstrated by a number of different authors it is very difficult to determine the true level of errors and as a result a number of different measures are used as a proxy to understand the scope and nature of such incidents. One measure is the number of claims made against the NHS. The situation in Scotland as outlined by the Central Legal Office was described earlier and suggests that the number and magnitude (in financial terms) are not rising as perceived. Fenn et al (2000) examined the cost of medical negligence claims in England. The study identified that during the last decade of the 20th Century the number of negligence claims (as measured by the rate of closed claims) rose by approximately 7% per annum. The authors acknowledge that this is a substantial rise but argue not the exponential rise often referred to in the wider popular press.

Untoward clinical incidents within nursing are as significant an issue for professional practice as for the medical profession. The majority of literature relating to clinical incidents within nursing relates to medication errors. The management of untoward clinical incidents is influenced by the managerial approach, which in turn is coloured by history. The militaristic origins have resulted in a punitive approach to dealing with

situations where something has gone wrong. Bassett identified this approach in her study of the management of drug errors. Abel-Smith (1960) concluded that

‘Faced with a crisis, the reaction of the nurse was to do and not to think. It served also to protect her from self-criticism if her efforts did not produce the required results. It was at least comforting to know that a recognized procedure had been perfectly performed even though it had been ineptly chosen.’

Weingart et al (2000) drew together a number of different studies to identify the epidemiology of medical errors and conclude: -

- ‘Although researchers regularly publish studies of medical error, adequate epidemiological information is limited to a few institutions, procedures and specialties. Because most studies were conducted in academic referral centres the results may not be generalisable to community based hospital and out patient care facilities.
- Comparing studies is difficult because research methods are not standardised. The lack of agreement about methods and the variable rigour of their application contribute to the variations found in error rates. There is a serious need for researchers to use consistent definitions and methods and for collaborative work on measuring error.
- Systems for monitoring and reporting error could provide the platform from which more detailed studies of subpopulations could develop. However, expecting that individuals will carry out health care flawlessly creates an environment in which clinicians are reluctant to report their errors. Universal underreporting, in turn, undermines the ability to measure error accurately.
- For these reasons the precise prevalence and magnitude of medical error is unknown but it is probably enormous. We are aware of no study showing that medical care can be provided without error. In fact, the more closely we examine patient care the more errors we find. No setting is free from hazards and no specialty is immune, and patients are at risk no matter what their age, sex, or health status.
- But the risk is not homogenous. Patients who are sicker, subjected to multiple interventions and who remain in hospital longer are more likely to suffer serious injury as a result of medical mistakes. Unless we make substantial changes in the organisation and delivery of healthcare, all

patients – particularly the most vulnerable – will continue to bear the burden of medical error.’

Stanhope et al (1999) undertook a small study to examine the reliability of adverse reporting systems. The research was undertaken within 2 maternity units and took the form of a retrospective analysis of 250 cases notes from each hospital. Staff reported only 23% of the 196 adverse incidents identified from the 500 case records. The risk managers identified a further 22% and the remaining 55% were only picked up following the case record analysis. The study concluded that incident reporting systems seriously underestimated the true level of reportable incidents.

As a follow up to this study Vincent et al (1999) attempted to identify why staff reported less than half the reportable incidents. Most staff knew about the reporting system but almost 30% did not know that a list of reportable incidents existed. Some interesting trends on which staff groups would report incidents also emerged. For example midwives were more likely to report incidents than doctors and junior staff were more likely to report than senior staff. Some of the reasons offered for not reporting incidents were: -

- Fears of junior staff that they would be blamed
- High workload
- The belief that the incident did not warrant a report (despite the fact the incident was designated ‘reportable’)
- Junior doctors felt less supported by their colleagues than senior doctors

The final point here is counter-intuitive to the finding that junior staff were more likely to report error than senior staff. It could have been expected that the lack of support made junior less likely to report errors. Once again the conclusion was drawn that incident reporting systems do not provide a reliable index of the rate of adverse incidents.

Meurier (2000) describes an approach using critical incident technique of clinical errors to illustrate how valuable qualitative information can be obtained from accounts in order to improve understanding of errors and their causes. In this study 20 registered nurses

were invited to produce a report using a critical incident technique of an error which had led to an adverse event, or potentially could have led to an adverse event, they had made in their professional practice. A number of these were then followed up by short interviews. In the paper published in 2000, one of the events is described in order to illustrate how the process can be used to provide additional information. The situation is analysed using Reason's Organisational Accident Model. However, the incident described detailed how a patient who had been admitted to a medical ward following a drug overdose eventually jumped from a window. Whilst the incident itself outlined a number of issues that may have contributed to the patient being able to jump out of the window, it could be argued that there is no error involved as such. Using the Organisational Accident Model a number of latent failures were identified including staffing of the ward, management support, communication, protocols and policies and training and there is little doubt that from the description all of these things could have been improved. However, it does not demonstrate that an error, per se, led to the patient having the opportunity to jump out of the window. Meurier states within the paper that the management blamed the 'F' Grade nurse involved and there is an implication that the individual nurse was duly punished. It is not described in the text within the Critical Incident Report and therefore it is difficult to draw these conclusions from the overall manuscript. It is also clear that there are individuals who have a clear determination to commit suicide; no matter what systems are in place however many staff are observing them, they will find a way if their determination is so strong.

O'Leary (2000) identifies how the accreditation system used within the United States i.e. the Joint Commission on Accreditation of Healthcare Organisations (JCAHO) can be used to reduce errors and adverse outcomes. The Joint Commission produces a number of standards against which participating organisations are measured. O'Leary argues that if organisations are doing "right things right" as presented in the standards then errors and adverse outcomes are less likely to happen than if there were no such standards. O'Leary goes on to argue

“It has become too easy to accept some undefined degree of medical errors as the inevitable by-product of today’s increasingly complex patient care and simply to blame and punish individual caregivers when things go seriously wrong.”

Within Scotland a similar set of standards is being developed through NHSQIS. The JCAHO has been in existence for a number of years and has been able to refine the standards across this period. NHSQIS (and its predecessors) are a recent development and will take some time to be able to have a similar impact on the NHS in Scotland.

[c] Medication Errors

Medication errors are the most common group of errors affecting qualified nurses. In a study into the factors underlying the occurrence and reporting of drug errors Gladstone (1995) identified a number of areas of concern. These included nurses’ confusion regarding the definition of a drug error, appropriate action to take when a drug error occurred, nurses’ fear of disciplinary action, nurses’ fear of loss of clinical confidence, variation in managerial response and the lack of nurses’ mathematical skills. Nurses’ reluctance to report drug errors is in part due to fear of reprisal (Osborne 1999). The United Kingdom Central Council identified and raised the same issue some time earlier that when nurses make drug errors under pressure of work they often become the subject of disciplinary action. Alderman (1997) identifies how organisational culture can be changed and the information obtained from medication errors can be used to improve nursing practice. The impact of a fatal medication error on those nurses involved in its administration can be overwhelming. Golz and Fitchett (1999) describe how the result of a drug error in which they were involved had a devastating effect on their personal and professional lives.

[d] Incidence

The incidence of drug errors has been quantified on a number of occasions. Cooper (1995) cites a number of studies in both the UK and the USA, with an error range from 2 to 18% (quoted by Raju et al (1989), Jessee (1981)) . Osborne et al (1999) report from several studies examining the number of reported errors, that recorded error rates range

from 1.6 to 38% of all medication errors. The literature clearly shows that inconsistencies of definition, data gathering, failure of recognition and lack of reporting makes the true scale of errors impossible to identify.

[e] Causes and Impact

Fuqua and Stevens (1988) identified four contributing factors to medication errors.

1. Inadequate knowledge or medication administration skills
2. Failure to comply with hospital policies and procedures.
3. Failure in communication.
4. Disruptive personal experiences.

Wolfe (1989) reflects these contributory factors and identified a number of situations, which preceded medication errors. These included errors in transcribing medication orders, distractions in the institutional environment, failure to absorb or act on information on drug packaging labels, confusion over similar packaging labels and container sizes, use of defective equipment and selection of the wrong medication container. Other factors included poor handwriting, selecting the medication from memory without checking the medication administration record, recording medication as given before it was administered, leaving medications at the bedside and scheduling medications during a change-of-shift report.

It is also clear that a number of medication errors are due to poor mathematical ability of nurses (Miller 1992). Often this leads to incorrect doses being administered by a factor of ten. Bayne and Bindler (1988) identify that many nurses are aware of this deficiency but are afraid to admit to it. A variety of strategies have been suggested to reduce the likelihood of errors due to mathematical inability, for example, the use of calculators (Shockley 1989) however in another studies (Eaton 1989) it has been noted that individual nurses may not recognise glaring errors. Use of two nurses to check medication doses is common practice particularly within paediatrics, however this could again be providing a false sense of security as Bayne and Bindler (1988) suggest that

nurses are unlikely to admit to their inadequacies with regard to mathematical ability. It has been suggested (Pirie 1987) that a complexity of calculations required to be undertaken by nursing staff are equivalent to those required in A level mathematics and the author goes on to argue that it would be impractical to suggest that this be an entry requirement to nursing programmes. However the current entry requirements for nursing programmes are not consistent between educational institutions and few, if any, require mathematical ability beyond basic secondary school qualification in arithmetic.

[f] Nurses' perceptions of medication errors

Osborne et al (1999) identified in their study nurses perceptions of medication errors. In their ranking of perceptions of cause the respondents in the study viewed the major causes of medication errors in rank order as;

1. Failure to check the name band of the patient with the medication administration record.
2. Fatigue and exhaustion on the part of the nurse.

Osborne et al's study ranked distraction as the fourth major cause of medication error, which was in contrast with the study undertaken by Gladstone where distraction was the No. 1 cause for error within the unit.

A number of authors have identified the fact that nurses are reluctant to report medication errors for fear of their potential repercussions (Gladstone 1995, Gibson 2001, Alderman 1997, Osborne et al 1999, Webster and Anderson 2002) Gladstone (1995) identified that there was considerable variation in what managers did or did not take into account when dealing with a drug error. These included the type of error, the type of drug, the actual or potential effect on the patient as well as other factors such as pace of work on the ward, staffing levels and the nurse's reaction to the error. Gladstone reports

“there was wide variation in the criteria if any used by the managers when deciding what action to take with regard to the nurse who had made an error. These criteria included the part of the system that had failed, any previous errors, the nurse’s insight and attitude to the incident and the possible extenuating circumstances.”

In a study examining nurse’s responses to errors Meurier (1998) reports three main findings. The first was that nurses were more likely to make internal causal attributions as a result of an error (i.e. they were more likely to blame themselves) no matter what the outcome of the error. The second finding noted that nurses were likely to attribute a lower importance to incidents with a less serious outcome. The third finding related to the influence of the outcome on an evaluation of an error. A number of issues arise from the findings within this study. By internalising the blame for an error a nurse may ignore some of the other factors that may have contributed to the error resulting in a less than full understanding of the antecedents to an untoward incident. All errors and near misses should be recorded and reported irrespective of the outcome. Once again this facilitates a fuller understanding of the types and causes of errors. Finally, the outcome should not be viewed in isolation as a criterion in relation to professional practice. Meurier argues that

‘If a nurse does something that is a violation of the expected actions or omits to carry out an important observation or instruction, then this should be taken as evidence of poor performance whether or not harm has been done to the patient.’

[g] Potential solutions to medication errors

Webster and Anderson (2002) advocate the use of anonymous incident reporting to reduce drug administration errors on hospital wards. In their paper they suggest the use of the systems approach to managing such errors. They acknowledge that systems do exist for reporting incidents within nursing however these typically are not anonymous and tend to focus on individuals rather than hospital processes. They argue that anonymity is an essential element of any reporting mechanism using the systems approach to error management. In their paper they identify a number of very practical ways in which medication errors could be reduced. For example in many drug trolleys within wards the drugs are stored in alphabetical order and they point out that the

alphabetical organisation is potentially dangerous as different agents are placed together simply because their names start with the same letter. They go on to argue that this problem is compounded by the fact that many drugs now are presented in non-descript bottles or packets. A similar issue is also demonstrated in relation to drug cupboards.

The use of computers has allowed the reporting of medication errors to be used in a positive way to identify common areas of error and ways of improvement. Sehati and Inkster (1995) outline the use of a software package, used to improve management of drug errors, in particular the use of reports resulted in the authors being able to identify;

1. The shift on which most errors are likely to occur.
2. The drugs most commonly given in error.
3. The healthcare professionals who are most susceptible to drug errors.
4. Drug error black spots.
5. The inconsistency of approach when dealing with drug errors.

The issue of medication doses within paediatrics is reported by a group of pharmacists in Liverpool who suggest the following systems to reduce the risk of over dosage: (Caldwell et al 2000)

1. Document dose calculation in the patient record.
2. Independent dose calculation checks by the pharmacist before the first dose is administered.
3. The removal of dangerous drugs from floor stock.
4. Supply of ready-to-use syringes.
5. Labelling should be in the same units

The issue of medication errors is the subject of much debate within the literature and in particular illustrates the direct and indirect costs of any error. Barber (2002) poses the question whether we should consider non-compliance as a medical error and reports that around one-third to one-half of patients does not take their medicines as directed. Having reviewed much of the literature in relation to error management, Barber concludes you

should not consider non-compliance as a medical error as the terminology is inappropriate however non-compliance has a substantial amount to learn from medical error theory and a merging of the approaches could benefit patients significantly.

O'Shea (1999) in undertaking a review of the literature dealing with the factors which contribute to medication errors concluded that :

- Medication errors are a persistent problem associated with nursing practice.
- The mathematical ability of nurses is highlighted as a problem area.
- In-service education in relation to medication management is required.
- Nurse managers should consider assessment of workload, nursing care delivery systems and staffing levels on different shifts.
- Medication errors are a multidisciplinary problem and require a multidisciplinary approach to identify solutions. This may address problems relating to poor adherence to policy and poorly written prescriptions.
- Interventions to reduce medication errors have been initiated, however as the problem persists the interventions do not have a long lasting effect.

It is clear from the literature that medication errors are a widespread problem within nursing practice and as therapies become more complex, the role of nurses in the prescribing and administration of medication will do nothing to reduce the likelihood of errors occurring. There are however a number of risk management strategies that can be employed to reduce the incidence and impact.

[h] Barriers to Reporting Incidents

Throughout the literature relating to clinical incidents there is a recognition that barriers to reporting incidents exist. As described earlier a number of authors identified this as a major issue on the management of medication errors. Lawton and Parker (2002) report on some research findings and conclude: -

- Healthcare professionals, in particular doctors, are reluctant to report adverse events to a superior.
- Healthcare professionals are more likely to report an incident to a colleague when things go wrong
- Healthcare professionals are more likely to report incidents to a senior member of staff, irrespective of outcome for the patient, when the incident involves a violation of a protocol.
- Even though it is unlikely to be reported, it is most likely when the incident represents the violation of a protocol with a bad outcome.

Dimond (2002) outlines some more fundamental reasons as to why healthcare professionals do not report adverse incidents. These are :-

- Lack of awareness of the need to report what and why
- Lack of understanding of how to report
- Staff feel that they are too busy to make a report
- Too much paperwork involved in reporting
- The patient recovers from the adverse event and the urgency goes out of the situation.
- Fear of point scoring by colleagues, retribution by line management, disciplinary action or litigation
- No evidence of timely feedback and / or corrective action being taken resulting from making a report.

These findings broadly reflect those reported by an American Study by Elnitsky (1997) whose study concluded that

‘Examination of nurses’ perceptions of supervisors’ beliefs about and use of incident reports revealed that 1) nearly 20% of nurses believed that supervisors used incident reports against employees; 2) 17% of nurses believed that their supervisors used incident reports against them in their professional evaluations; and 3) 25% of the nurses reported they were

afraid that supervisors would have a negative view of their skills when they reported an incident.'

Ootim (2002) quotes Tariq Hussain, a former UKCC Director of Professional Conduct, in exposing an attitude of "sack now – ask questions later" of some hospital managers being a major reason for the non-reporting of errors. Ootim also suggests that in the United States there tends to be "a knee-jerk reaction" by those in authority to blame the individual for a nursing error. A review of further literature however suggests that this has been the situation in the United Kingdom for some considerable time and Ootim's suggestion that the situation in the UK is only now beginning to reflect the situation in the USA, does not appear to be a reasonable one. There are many high-profile examples of where this has occurred within medicine even where there is a perceived old boys network, which is extensively used to protect perpetrators of errors. In nursing it is suggested that the hierarchical and militaristic nature of nursing and the "hand-maiden" role that nurses play to doctors have contributed to a tendency within nurse management to apportion blame to an individual for an error.

[i] Recognising and Reporting Errors

One significant barrier to reporting an incident is recognising that an error has actually been committed. This should also be examined alongside what Elnitsky et al (1997) describe as nurses' incident-reporting behaviours. In a study, which recruited qualified nurses from hospitals located in a southeastern coastal state of the United States, it was revealed that 36% of the respondents 'believed that some incidents do not need to be reported.' In drawing comparisons with other studies Elnitsky draws attention to the study reported by Sutton et al (1994) from the UK and states;

'The validity and reliability of incident data, however are in question. The number of documented incidents represents only a portion of all incidents occurring in hospital included in this study and others. Nurses' incident reporting behaviours revealed that some incidents are not reported. Thirty-six percent of nurses surveyed believed that some incidents do not need to be reported. This finding is consistent with that of Sutton et al who reported that 35% of incidents were unreported.'

However on closer examination this is an invalid comparison between two different measures. Elnitsky's study examined the responses of nurses whereas Sutton's study relied on patients indicating that nurses knowingly did not report accidents. Sutton (1994) warns that

‘The possibility of some patients exaggerating or overestimating the occurrence of unreported incidents for their individual reasons should not be dismissed.’

It is therefore reasonable to conclude that nurses under-report accidents and incidents. In the main this relates to (i) the nurse does not recognise that an error has been made (ii) the nurse does not regard the incident as requiring to be reported (iii) the nurse is fearful of the potential consequences of reporting incidents.

There are some examples of local reporting systems, which have demonstrated that changes can be made to prevent recurrence of certain types of errors. James (2003) illustrates an incident reporting scheme within a hospital group functioning for eleven years and reporting on one thousand incidents. James goes on to describe some of the features believed to contribute to the success. These include a clear and shared understanding of the definition of an incident; the assurance of anonymity (except in those cases where harm has occurred), the voluntary nature of the reporting; maintaining enthusiasm by presenting results every quarter and demonstrable changes to preventing recurrence. As confidence in the system has developed, individuals have been willing to provide their name voluntarily.

[j] Organisational Culture in Reporting Errors

In an interview for the Harvard Risk Management Forum, Lucian Leape, points out that there are two main ingredients needed to be present within an organisation to develop an organisational culture which is safety conscious. These are effective leadership from the Chief Executive and a non-punitive environment. He goes on to say that there has to be an edict that says “we do not punish people for making or reporting errors. Period. We only punish people for misconduct.” When asked to elaborate on the difference between

the two he argues that 'Very few errors are due to misconduct. Most errors are caused by systems failure not people failure.'

Nolan (2000) argues that in order to improve patient safety by reducing the number of errors, the strategies for the design of safe systems of care have to be adopted. He goes on to suggest that designers of systems of care can make them safer by attending to three tasks:

1. Designing the system to prevent errors
2. Designing procedures to make errors visible when they do occur so that they may be intercepted
3. Designing procedures for mitigating the adverse effects of errors when they are not detected or intercepted

Nolan illustrates this point by illustrating a common error when using Automated Teller Machines (ATMs). It was noted that a large number of individuals left their bankcard in the ATM once they had received their money. It was suggested that the reason this was happening so frequently was the primary purpose of going to an ATM is to obtain money. Therefore, once you have received it the principal task is complete and removing the card is forgotten. The original system dispensed the money before returning the card. In order to prevent such errors the system was changed so that the card was returned before the money was dispensed. Indeed this was enhanced even further in that cash would not be dispensed until the card was physically removed from the ATM. Therefore the individual must always take their card and, given the primary purpose was to obtain money, collect the money dispensed. This illustrated how a system could be modified in order to reduce / eliminate the identified error.

This example illustrated by Nolan identifies how human factors in systems lead to errors. Weinger et al (1998) argue that a significant way of reducing errors involving medical devices is to incorporate human factors into the design of such devices at the outset. They go on to suggest that the patient's safety will be enhanced if the medical community demands better-designed medical devices through standards, regulations and market forces.

This apparent failure to incorporate human factors into design is not however restricted simply to medical devices. A first alert from the National Patient Safety Agency (NPSA) identified that concentrated forms of Potassium had been prepared in similar vials to water or normal saline resulting in Potassium being used to dilute venous drugs resulting, in some cases, in death. Wilson (2001) illustrates a similar issue whereby a company produced a bottle of stoma deodorant closely matching a bottle of eye drops, demonstrating the potential for a stoma deodorant to be inserted into the eye. Wilson also argues that there is an even greater likelihood of this happening given that the very reason the patient requires eye drops may be due to poor eyesight.

Shaw (2001) identifies that changes within organisations are only effective when behaviour changes accordingly.

‘Institutional policies, standards and guidelines are only effective if people whose actions they are intended to influence are aware of them, understand them and are able to comply with them as written. The mere existence of such policies, standards, guidelines and protocols does not guarantee their compliance neither does the dissemination of such information.’

[k] Reporting Systems.

Pinker (2002) reports that the organisational culture within the Quebec region of Canada has changed dramatically whereby the Quebec College of Physicians and Surgeons has moved to change its code of conduct to expect its members to reveal errors to patients as quickly as possible or face disciplinary action. The Quebec government has then followed suit and expects hospitals within the region to adopt the same approach.

In another part of Canada, Vancouver, staff are encouraged to discuss adverse events openly and honestly. Kent (2002) reports that multi-disciplinary staff within one unit discuss adverse events or near misses on a regular basis in what are described as ‘safety huddles’. In some instances the solutions to preventing a repeat of an adverse incident or preventing a near miss becoming a full-blown incident are very simple. These two very

different approaches have been adopted within Canada and as yet there are no available studies to demonstrate which is the more effective.

[I] Approaches to Managing Errors

Reason (2000) identifies two approaches to managing human error, the person approach and the systems approach. The two different systems are summarised as :-

- The person approach focuses on errors of individuals, blaming them for forgetfulness, inattention, or moral weakness.
- The system approach concentrates on the conditions under which individuals work and tries to build defences to avert errors or mitigate their effect

The person approach

This approach remains the dominant approach within healthcare as well as some other industries and it has been argued that such an approach is counter-productive to the development of a safety culture within organisations. By focussing on the acts of individuals the organisation fails to recognise the context in which the error occurs and as a result there is a failure to identify recurring errors and their causes. Reason argues

‘The pursuit of greater safety is seriously impeded by an approach that does not seek out and remove the error-provoking properties within the system at large.’

The systems approach

The systems approach to managing errors is geared towards making changes to systems in order to reduce or mitigate the effects of errors. Nolan (2000) in reviewing literature surrounding improving systems identifies 5 categories of system changes, which will reduce errors and adverse events.

1. Reduce complexity
2. Optimise information processing
3. Automate wisely
4. Use constraints

5. Mitigate the unwanted side effects of change.

Hall (2002) however dismisses the notion that systems are at the root cause of mistakes arguing that this is a flawed argument based on a philosophy of structuralism and should be replaced by virtue ethics. Hall goes on to argue that systems do not make errors – people do. She argues that: ‘The new philosophy of deconstructivism also does not offer any solution to the management of errors.’ Hall points to virtue ethics as a way of reducing errors and identifies how this may be viewed

‘Virtue ethics means character counts, that being a virtuous person matters. Translated into 21st-century patient care, it means that you see people who care for patients as individuals, and you hold their caregivers responsible for their actions. People are not mere cogs in systems. They are human beings who can be held accountable for their acts, including their mistakes.’

[m] Who makes errors?

Ootim (2002b) cites Bell et al (1997) who concluded that skilled performers of cognitive tasks make fewer errors than novices. Reason (1990) however would argue that even the most skilled performers could make errors, which have disastrous outcomes. Ootim goes on to make the point that undetected errors are particularly problematic in that when an error is detected appropriate corrective action can be taken either at the time or at a later stage to minimise the impact of the error. No such corrective action can be undertaken with undetected errors. Reason (2000) argues that it is often the best people who make the worst mistakes. Error is not the monopoly of an unfortunate few. Henry (2000) in an editorial covering quality of care, health system errors and nurses, identifies that despite the growing body of evidence of systems failures, managers and other authorities continue to blame, and seek to blame, the person who was involved in that error.

Donchin et al (1995) reported a study involving an examination of errors within an intensive care unit. The two data sources were the incidents reported by nurses and physicians immediately after they happened and observations undertaken on a sample of patients by individuals’ experiences in human engineering. The study reported that nurses

committed a greater proportion of the errors than those committed by doctors. This conclusion applies to both the reported errors (nurses 54%, doctors 46%) and observed errors (nurses 60% and doctors 40%). However, the conclusions recognised that the complex interactions between the two staff groups play a significant role.

‘A significant number of dangerous errors occur in ICU. Many of these errors could be attributed to problems of communication between the physicians and nurses. Applying human engineering concepts to the study of the weak points of a specific ICU may help to reduce the number of errors. Errors should not be considered as an incurable disease but rather as preventable phenomena.’

This study makes an attempt to quantify the rates of errors among and between doctors and nurses within a specific setting and illustrates the inter-relationship between the two different groups. Whilst it does not draw specific conclusions around blame it could be suggested that the nature of these interactions makes it very difficult to pin-point the exact cause of errors and as such makes it difficult to apportion blame to an individual. This is a conclusion suggested by a number of different authors.

Summary

The available literature demonstrates the increasing interest in errors, their causes and management. Inextricably linked with this is the issue of blame and how it is apportioned. These issues generated the interest of the researcher and stimulated the development of this area of study. There is a strongly held belief that nurses, in the pursuit of managing nursing, sought to blame nurses for errors. The purpose of the research is to determine whether this belief is matched by reality. If so, why is this the case? As outlined earlier, within the literature there is a strong body of evidence from social scientists that this is, in part, related to the origins of nursing and the way it has developed as a profession.



4. ORGANISATIONAL ISSUES AND LESSONS FROM OTHER INDUSTRIES

In any examination of error management within the health service it is important to identify lessons from other industries. Different industries have identified processes for managing errors and more importantly how these contribute to organisational development. Helmreich (2000) draws comparison between how errors are managed within the aviation industry and health services. He identifies three main sources of data used to manage errors.

1. Confidential survey of pilots and other crewmembers.
2. Non-punitive incident reporting systems.
3. Observational methodology.

Through this data collection, errors are categorised which in turn is useful in identifying different interventions to mitigate different types of errors. Five different types of errors are identified as:-

1. Proficiency errors
2. Communication errors
3. Non-compliance errors
4. Procedural errors
5. Decision errors

Each error is categorised and a mitigation strategy adopted to prevent it recurring. For example errors categorised as proficiency errors require technical training or retraining, whereas communication and decision errors require team training. This model has been adapted for use in health care settings and in particular within the operating theatre. There is recognition that the operating theatre is a more complex environment than a cockpit and the more obvious difference that 'Aircraft tend to be more predictable than patients.'

However, there are a number of different behaviours, which may contribute to increase the risk to patients within an operating theatre. These are;

- Communication
- Leadership
- Interpersonal relationships, conflict
- Preparation, planning, vigilance

One of the training strategies used within the aviation industry is the use of simulators. Within healthcare, anaesthetics was one of the first disciplines to embrace the notion of error management. This specialty is also one that lends itself to the use of simulators. A centre for training has been established in which a mock theatre has been established where a mannequin connected to a computer programme can simulate different problems experienced during a general anaesthetic. This allows trainees to react to different situations and manage problems without danger to patients. It also allows the development of potentially high-risk techniques such as difficult intubations.

The use of simulators is now an integral part of education and training of medical and nursing students as well as the skills development programmes for qualified staff. These are outlined by a number of different authors: Anaesthetics (Merry et al 2002, Forrest et al 2002, Devitt et al 2001, Byrne and Greaves 2001, Jacobsen et al 2001, Morgan and Cleave-Hogg 2000), Surgery (Paisley et al 2001), Urology (Ballaro et al 1999), Gynaecology (Hadzimahmtovic et al (1999).

Barach and Small (2000) identify methods of reporting incidents, errors and near misses in aviation, petrochemical processing, steel production, nuclear power and the radio pharmaceutical industries. In comparing the differing systems in other industries with those within medicine a number of conclusions were identified.

- Research studies have validated an epidemic of grossly underreported, preventable injuries due to medical management.

- Recent policy documents have placed high priority on improving incident reporting as the first step in addressing patient injuries, and have called for the translation of lessons from other industries.
- Complex non-medical industries have evolved incident reporting systems that focus on near misses, provide incentives for voluntary reporting, ensure confidentiality whilst bolstering accountability, and emphasise perspectives of systems in data collection analysis and improvement.
- Reporting of near misses offers numerous benefits over adverse events; greater frequency allowing quantitative analysis; fewer barriers to data collection; limited liability and recovery patterns that can be captured, studied, and used for improvement.
- Education and engagement of all stakeholders of health care and negotiation of their conflicting goals will be necessary to change the balance of barrier incentives in favour of implementing reporting systems.

McCune (2000) argues that airlines now have rigorous psychological assessment for pilots and concludes that

‘psychological assessment of doctors or medical students, or both, along with training in recognising personality types and error-prone situations could be of benefit to both practitioners and patients.’

Sexton et al (2000) examine the methods adopted within medicine and aviation and conclude that

- Medical staff are more likely than aviation staff to deny the effects of stress and fatigue.
- Cockpit crews and intensive care staff advocate flat hierarchies but surgeons are less likely to do so.
- Error is difficult to discuss in medicine and not all staff accept personal susceptibility to error.

Robinson (2002) demonstrates the similarities between the emergency services and aviation. The main areas of similarity are ;-

- High stress environment
- Decisions with life or death consequences
- Rapid decision-making
- Many distracting factors
- Amenable to protocols

In drawing comparison between the approach taken in some industries and that taken by the NHS, Ottewill (2003) concludes that;-

‘...the NHS has lagged behind other industries in recognizing the ubiquity of human error and implementing cultural changes to minimize its effect. The person approach to human error and the inherent blame culture has been shown to have serious shortcomings. This situation is neither to the benefit of professionals nor patients. Although it has a certain attraction for managers, deflecting blame from organisational and leadership failings does nothing to correct weaknesses in systems and so will not prevent future error. In the long term therefore it is in no-one’s interests at all.’

This conclusion however does not take account of personal failings and how these can be dealt with within the approach suggested by Ottewill. It could be argued that there is little to be gained by managers in seeking to deflect blame from the organisation to the individual. Equally it could be argued that it is convenient for perpetrators of errors to attribute the cause to perceived organisational failings in order to deflect focus away from a personal weakness.

The comparisons with other industries are helpful in demonstrating how a systems approach to incident management can reduce the risk of a recurrence and empower staff to report incidents and near misses freely. However, the number of variables characterised by the complexity of human interactions within healthcare are considerably greater than those experienced, for example, in the airline industry. Therefore, a wholesale

adoption of incident management methods from such industries into healthcare is inappropriate.

[a] Clinical Governance

Clinical Governance as a concept was described in the Department of Health's 1997 white paper *Designed to Care*. One minister for health described this as 'corporate accountability for clinical performance.' The intention was the political desire to move away from the heavily finance biased agenda of the internal market towards a concentration of the clinical quality of care. Sam Galbraith, the Minister for Health in Scotland described the new term thus

'Clinical governance is the vital ingredient which will enable us to achieve a Health Service in which the quality of health care is paramount. The best definition that I have seen of clinical governance is simply that it means "corporate accountability for clinical performance". Clinical governance will not replace professional self-regulation and individual clinical judgement, concepts that lie at the heart of health care in this country. But it will add an extra dimension that will provide the public with guarantees about standards of care.'

What is particularly important about this statement is that it relates to clinical care in its widest sense; it is not restricted to doctors. Given the timing of its inclusion in the White Papers covering Scotland and England so soon after the revelations from Bristol, it has often been associated with these events, which were primarily medical issues. Lugon and Secker-Walker perhaps summarise these views in the introduction to their book *Advancing Clinical Governance*, where they comment that

'Society's view of clinicians has recently undergone a sea change. This has followed from a series of high-profile medical disasters, which have received considerable media publicity. This has forced the present government and the NHS to be seen to be putting their house in order. Clinical governance became an integral part of the 1999 NHS Act.'

It is interesting how the use of the terms clinician and medical are used almost synonymously. Whilst there can be little doubt that some high profile clinical 'disasters' influenced the issues around clinical governance there is no evidence to conclude that

these were the exclusive reasons for the inclusion of this new concept into the White Papers. The primary reason relates more to the desire of the then new government wishing to be seen to stamp its new authority on a health service run by its political opponents for many years. It was an attempt to redress the perceived imbalance between the comparatively heavy emphasis placed on financial management as opposed to quality of care often perceived by clinicians as less important to managers and politicians. Clinical Governance is perhaps the most significant policy development in recent years in providing a framework within which clinical care could be improved. Managers and clinicians could use clinical governance as a tool to improve both the delivery of care and the environment in which care is delivered.

Wilson (2002) in Tingle and Cribb, illustrates that clinical governance incorporates a number of different process including :-

- Clinical audit
- Evidence based practice in daily use supported within the infrastructure
- Clinical effectiveness
- Clinical risk management with adverse events being detected, openly investigated and lessons learned.
- Lessons for improving practice are learned from complaints
- Outcome of care
- Good quality clinical data to monitor clinical care with problems of poor clinical practice being recognised early and dealt with.
- Good practice systematically disseminated within and outside the organisation and clinical risk reduction programmes of a high standard being in place.

One important area, which Wilson has omitted in the list identified above, is the involvement of patients, carers and the wider public in clinical governance processes. Kelson (2001) in Lugon & Secker-Walker outlines that this is an area, which has been a key feature in a number of policy frameworks (The White Paper The new NHS and A First Class Service). Kelson goes on to suggest that patient involvement (for the purposes

of the publication Kelson uses the term 'patient' to include patients, service users, carers, members of the public and members of groups representing their interests) can be achieved at two main levels:

- Individual involvement – For example the central role of patients in decisions about their own health and care.
- Collective level – For example patient representatives' actively contributing to NHS policy and planning.

[b] Risk Management

The management of risk within the clinical setting is in itself not a new concept. Clinical staff have argued that almost all clinical interventions involved some form of risk management that has become part of the caring process as they have become more experienced. However, the concept has developed into a more structured framework within which clinical care and the environment in which it is delivered can be systematically evaluated in order to assess, identify, prioritise and effectively manage risks. At an organisational level such risks apply to wider organisational issues such as finance.

[c] Summary

Whilst authors have identified similarities between the NHS and other industries, and identified the need to change an organisation's culture, few have acknowledged the difficulty in changing cultures within long-standing professions developed over centuries. The researcher argues that this is key to understanding why there are significant barriers to simply lifting a system of regulation from one industry, superimposing it into healthcare and expecting to achieve similar results. The challenge is undoubtedly the shift of organisational culture within the NHS to one more akin to other high-risk industries. This in itself is a difficult and challenging process. When the need to change the culture within professions is added the magnitude of the challenge increases several-fold.

5. THE CONCEPT OF BLAME

[a] The nature of blame

The concept of blame is central to the main aims of the research. In different settings there are different interpretations of blame.

The Oxford dictionary defines blame as; assign fault or responsibility to, assign the responsibility for (an error or wrong) to a person, responsibility for a bad result; culpability, the act of blaming or attributing responsibility.

The Oxford thesaurus identifies a number of synonyms

Find fault with, censure, criticise, fault, accuse, charge, indict, condemn, point to, point (the finger) at, rebuke, reprimand, recriminate, reproach, scold, reprehend, reprove, hold responsible, fix the responsibility upon, put or place or lay the blame, culpability, responsibility, guilty.

Within the field of social psychology research, blame is investigated in how we either accept blame or attempt to apportion blame to others. Tennen and Affleck (1990) review a number of studies looking at blame attribution and find that there are two different schools of thought with regard to blame – the psychoanalytical school views blame as a developmental diathesis and the social psychology literature, which sees blame as ‘learned helplessness’ and ‘excuse theory’.

Campbell-Tiech (2001) in discussing the European Convention on Human Rights delivers a fairly scathing attack on society as a whole and argues that this is

‘...symptomatic of what I perceive to be a deeper malaise; we are, as a society, overly attached to the concept of blame. It is not sufficient that you are right; someone else must also be shown to be wrong. In apparently empowering the individual against the state we have moved further away from the acceptance of risk, from the recognition of the fact of accident. Negligence is nowadays such an all-embracing concept that there is little if any room for the defence of accident. The results of this way of thinking are slowly seeping into public consciousness. Teachers cancelling the field trip, the rugby coach requiring insurance, the restaurateur seeking an

indemnity in advice from his reputable supplier: all join the doctor practicing defensive medicine and the lawyer whose advice is so convoluted as to be worthless (but safe).'

LaDuca (2001) draws our attention to the issues of competence and blame. Whilst the paper deals with the competence of doctors the issues relate equally to the competence of nurses or indeed any other skilled individual. It is argued that;

‘...attention is directed to mechanisms for assuming that the doctor has maintained the competence we certified at some earlier time. Usually our effort centres on the doctor, but it is essential to recognize that the process of evaluating the doctor draws our attention inevitably to evaluating the situation. We confront the need to distinguish the blameworthy error from the blameless misfortune.’

Essentially LaDuca argues that there is a need to examine the entire context of the situation rather than concentrating on the individual before we can decide whether blame can be attributed.

Merry and McCall-Smith (2001) consider 5 different levels in the classification of blame.

Level 1 : The first level is pure causal blame, where the agent is identified as the physical cause of an event but has acted reasonably, has broken no rules and has done nothing wrong in moral terms.

Level 2 : The second is blame attributed for an action, which unintentionally deviates from or falls short of what can normatively be expected of the actor (that is the way of doing things prescribed in the textbook – the ‘theoretical norm’).. but no moral culpability exists. This may be construed as negligence if conduct is measured against an absolute standard and fails to take account either of the fact that the reasonable person is a human being with all the limitations that status implies, or of the state of mind of the individual at the time.

Level 3 : The third level is blame attributed for an action, which deviates from or falls short of what can reasonably be expected of the actor (that is the way things are done by people of reasonable competence in the field – the ‘empiric norm’) and where moral culpability may exist even though there is no intention to cause harm.... People can only be morally

accountable for those acts which they have chosen to perform; things which they could not reasonably have avoided doing should not be laid to their moral account.

Level 4 : The fourth level of blame is appropriate for situations where the actor knows of the existence of risk and nevertheless proceeds with the action. This is recklessness.

Level 5 : The fifth level entails an unambiguous intention to cause harm.

Alderman (1997) illustrates the need to move away from the system whereby nurses are blamed for medication errors to one in which a culture of openness allows a nurse to report such incidents and near misses in a punitive free environment.

In an extensive discussion around the ethical issues involved in adverse events Krizek (2000) identifies five major hurdles to improving quality within surgical practice :-

1. Inadequate data about the incidence of adverse events
2. Inadequate practice guidelines or protocols and poor outcome analysis
3. A culture of blame
4. A need to compensate 'injured patients'
5. Difficulty in truth telling.

All these hindrances are in someway related to the culture within an organisation.

[b] Apportioning blame

Whenever something goes wrong in a hospital there is usually frenzied activity within the media, management and public. The Kennedy report following the affairs of paediatric cardiac surgery cases in Bristol resulted in a breakdown of confidence in medical professions. It is not clear if this influenced Baroness O'Neill of Bengrave's choice of subject for the 2002 Reith Lectures, but the issue of Trust was the main theme of the five lectures delivered throughout the first part of 2002.

In an emotional letter to the BMJ in 2000 an anonymous writer explained that as a result of the trauma, which they experienced following an incident and the subsequent retraining that they realised that ‘blaming individuals is more emotionally satisfying than targeting the institution.’ The anonymous author draws comfort from the conclusion reached by Reason in an earlier article in the BMJ that found that ‘It is often the best people who make the worst mistakes.’

Warden (1996) outlines the proposed new powers for the Health Service Ombudsman as being a change which would do nothing to expel the impression of a blame culture within the NHS. He quotes the paper describing the new powers of the Ombudsman being

“without seeking in any way to encourage or promote the blame culture it is the Ombudsman’s responsibility to criticise where, in his view, the patient does not receive the service he is reasonably entitled to expect.”

Grant (1999) provides yet a further example of how media can not only distort the facts of the case but also prolong the agony of nurses involved in tragic error. Grant describes how, at the time of an incident, the Massachusetts Department of Health did not refer the nurses to the governing body, that an internal investigation and two further external investigations undertaken by the Massachusetts Department of Public Health, the Joint Commission on Accreditation of Health Care Organisations and the National Institutes for Health found no fault with any individual nurse. Despite this, four years later, the Massachusetts State Board of Registration and Nursing proposed sanctions against the nurses involved without ever having conducted an appropriate investigation into the case. This would tend to demonstrate in this particular case, which may be replicated in other areas, nurses’ and nursing’s apparent predisposition towards attributing blame.

In reporting some of the proceedings of the Bristol enquiry which set out to investigate the circumstances behind a number of paediatric deaths, Healy (2000) reports a number of calls to remove the blame culture within the NHS in order to allow the service to learn from its mistakes. Nigel Ofen, Head of Clinical Quality at the NHS Executive Eastern Region is quoted as saying “until we remove the blame culture, we cannot move forward.”

We have to remember that a generation of doctors was brought up in a medical education system that was about being put down if you got it wrong. In the same report, Karen Parsley, Director of Nursing at Brighton Healthcare drew parallels with the aviation industry that the lack of blame culture allowed pilots to have regular feedback sessions as a result of simulated exercises. Two other important differences were presented, i.e. the NHS was more hierarchical in its organisation structure than the aviation industry, and also junior pilots are encouraged to report concerns and they are listened to by their senior colleagues, the implication being that the same could not be applied to medicine. Deirdre Hind, the Chair of Commission for Health Improvement, backed the call for a no blame culture and argued that it is essential that both the public and the media reduce the humiliation, blame and pillorying of people who admit their mistakes.

Recognising that a number of commentators have drawn parallels with the aviation industry, Nottingham (2001) advances the analogy between medicine and aviation, arguing that

“there are some branches of medicine in which not only is the doctor the only pilot on the flight deck but he is flying in a converted second world war bomber with questionable reliability. I would dearly love to fly in such an aircraft but whether I would chose to fly in one to the United States is another matter. The airlines (the NHS in this case) are unable to afford to replace the aircraft regularly and who flies the plane when the pilot is away being updated. The passengers (patients) do not like being kept waiting and often there are no spare parts”.

Nottingham presents one other major difference between the aviation and healthcare system by recognising that there are considerable data collected on adverse incidents in the aviation industry but asks the question “where is this information?” Which airlines regularly fly with aircrafts that are mechanically dangerous? Which is the world’s worst airline or the most dangerous airport? Where does one find this information out? Is there aviation or pilots league table similar to the hospital league tables that we hear so much about? How much choice do I get over who flies me when I next board the plane? Nottingham concludes that mistakes do however occur. When they do, consultants may be suspended or lose their jobs and the media reaction is unforgiving and predictable.

Disclosure of the mistake to the patient may cause legal proceedings to be started. This is not much incentive to own up.

In an editorial in 2001, the Canadian Medical Association reported the case of a four-day-old girl undergoing cardiac surgery, which tragically was not successful. This death was the twelfth in 1994 and resulted in the closure of the cardiac surgery programme. It was concluded that errors occurred at all levels of the cardiac surgery programme, in its hiring procedures, lack of monitoring, lack of a complaints procedure and even in the administrative decision to develop a paediatric cardiac surgery programme at a centre with a caseload too low to sustain excellence. The Assistant Chief Judge undertook an inquest into the deaths during the cardiac programme. He concluded that error is a human reality and the Canadian Medical Association adds to this, claiming that blaming is also a human reality. The editorial goes on to conclude

“everyone who has studied problems of error in medicine agrees that the prevention of errors requires identification and frank non-punitive investigation and discussion. As in other complex activities such as aviation, the identification of errors should be active not passive, focusing on not just catastrophic events but on near misses that could have been catastrophic but were not. It is always easier to find a scapegoat than to change the culture of a working environment but we must find the resources and muster the personal resolve to look at what we do in a systematic way, prospectively as well as retrospectively, expecting errors and developing non-blame mechanisms for preventing them.”

Sibbald (2001) again draws parallels between the reporting of errors between medical spheres and aviation. It poses the rhetorical question why medicine does not follow aviation's lead in reporting errors. One suggested reason is the potential for litigation.

“The Director of Research and Education at the Canadian Medical Protective Association is saying that there is no privilege (exemption from legal action) following disclosure. In other words, people reveal medical errors at their legal peril. Sibbald also goes on to draw parallels between the system in Canada and those in Australia and the United Kingdom and interestingly describes the setting up of the database of errors by the National Patient Safety Agency as a mandatory no name, no blame national system for reporting failures, mistakes and near misses which is

some way short of the reality. In Australia, the Australian Incident Monitoring Study (AIMS) has allowed healthcare workers to voluntarily and anonymously report incidents and accidents.

The pervasive nature of the blame culture within the NHS is not however restricted to clinical errors. Bradshaw (2002) illustrates how the blame culture is perpetuated by Government Departments, i.e. Department of Health on managers and the reforms are not implemented quickly enough or indeed the suggested positive outcomes are not realised. Bradshaw argues that

“the system of Health Service delivery creaks under the weight of Government reform and when things go wrong there is one particular target group to blame, that is NHS managers who are already reeling from target fatigue, arising from the volume and pace of the current reforms.’

Bradshaw also shows that blame is a convenient escape route. He argues that it avoids Government shouldering national accountability and is convenient because NHS managers are not particularly well liked by the general public. Thus the Audit Commission Report in 2001 on waiting times in Accident and Emergency, which concluded that waiting times had worsened nationally and blame for this was promptly placed on managerial shortcomings

“criticising managers is also far easier than doing something really radical such as imposing a user charges for an A&E visit which is the most effective way to reduce unnecessary attendance.”

In reviewing a new text “The Trouble With Blame: Victims, Perpetrators and Responsibility”, Simon (1996), makes the point that;

‘The trouble with blaming is doing too much or too little. Obviously there is a place for blame, but it must not be used as a means of obscuring the reasons for our actions, whatever they may be.
...Balance is the key.’

Whilst the text under discussion related to perpetrators and victims of sexual and physical abuse, the issue of apportioning blame applies equally to the management of clinical incidents.

The issue of blame within healthcare is not peculiar to the British NHS. This is an issue which has and is being tackled in most healthcare systems. Within Canada, the United Kingdom was being identified as an exemplar in developing an open culture of reporting errors via the National Patient Safety Agency. Sibbald (2001) argues one of the reasons that there is lack of disclosure in Canada is that there is no privilege (exception from legal action) following disclosure. Inaccurately she then goes on to suggest that this is the case in the United Kingdom, by suggesting that

‘In the UK a mandatory no name, no-blame national system for reporting failure, mistakes and near misses should be implemented by the newly formed National Patient Safety Agency by the end of 2002. It aims to reduce the number of serious prescribing error by 40% by 2005.’

Anonymous reporting of incidents with the NHS is not as yet a reality. However, in his consultation document entitled ‘Making Amends’, the Chief Medical Officer of the Department of Health, makes a number of recommendations including:-

- Statutory provisions would be introduced to encourage openness in the reporting of adverse events. This would encompass:
- A duty of candour requiring clinicians and health service managers to inform patients about actions which have resulted in harm.
- Exemption from disciplinary action for those reporting adverse events or medical errors (except where there is a criminal offence or where it would not be safe for the professional to continue to treat patients)
- Legal privilege would be provided for reports and information identifying adverse events except where the information is not recorded in the medical record.

[c] Blame and The Patient’s Perspective

There are some important issues, which require to be explored around the patient’s perspective in relation to clinical incidents. The earlier discussion related to how the public’s perceptions may be influenced by how untoward incidents are reported in all

areas of the media. It is understandable that the general public are concerned about incidents and their concern is equally understandable when they are apparently told that the culture within the NHS should not seek to apportion blame to whoever was responsible for an untoward incident, particularly when such an incident has resulted in the death of a patient. This was very clearly articulated by one patient representative who comments on an incident where the wrong kidney was removed, that

‘A perfectly fair consumer perspective is: If you cannot tell right from left then are you fit to practice?’

Whilst the reality of the situation was somewhat more complicated than not knowing left from right but a recording error that was made and not corrected and this subtlety was not lost on this commentator and he goes on to acknowledge

‘Although I understand all the valid reasons for avoiding a culture of wholesale blame, patients are entitled to require the people whom they trust with their lives to take responsibility and be held accountable for their actions. If the medical profession cannot cope with this reasonable demand, rebuilding public confidence in its trustworthiness will prove to be more of an uphill struggle than it need be. It may be hard in so far as scarcely any doctors deliberately damage their patients, but the public expects privileged professionals to accept their obligations, including penalties for inexcusable carelessness. Perhaps readers can explain why professionals should not suffer the consequences of gross carelessness like employees in every other trade and calling.’ (Goss 2000)

This is possibly the biggest challenge to healthcare professionals i.e. finding a way in which clinical incidents can be managed in as fair a way as possible to the individual practitioner whilst at the same time ensuring that current and future patients maintain their confidence in individuals, groups of staff and the institution as a whole.

The issue of disclosure of an incident to a patient has provoked much debate. The arguments have been polarised. At one end the approach is the patient’s right to be told everything about their care and at the other the approach is if there is no harm there is no point in worrying the patient. The Health Committee of the House of Commons in 1999

published a report entitled “Procedures Relating to Adverse Clinical Incidents and Outcomes in Medical Care”. The Royal College of Physicians of London prepared a statement to contribute to the report in which it is acknowledged that adverse outcomes were concealed from patients.

‘There is no doubt that in the past some incidents and adverse outcomes were concealed from patients, their relatives and management. It must not be assumed that the motivation for such concealment was necessarily a guilty attempt to avoid blame. Many well-meaning professionals believed that the complete disclosure might simply cause increased anxiety in the patient and relatives, which could interfere with subsequent care. It was always the case that steps were taken to minimise and alleviate the adverse effects produced. (Royal College of Physicians 2000)’

There is no doubt that much of what is described here may well be the case but it is this type of paternalism which so often angers patient groups.

The rise in consumerism principles within society as a whole has not only resulted in the approaches being adopted by patients and their representatives as described above but the courts have also had to change their approach. Edozien (2001) describes how accepted medical practice may be negligent and outlines a number of rulings illustrating the courts have changed and concludes that:

‘The courts reserve the right to decide that even accepted medical practice may be negligent. For policy reasons they have seldom used this right but in line with consumerist pressure in society at large, this position is shifting and the courts are now exercising the right more often. The challenge is to find the appropriate balance, which upholds the rights of the individual whilst protecting the overall interest of society.’

[d] Summary

How blame is apportioned has become an area of interest within the NHS in relation to what has been described as a culture of blame. In an attempt to move away from this there have been a number of calls for a blame free culture. At its most simple this would suggest a culture in which there is no blame apportioned. Yet those who call for such an outcome are unclear as to what this organisational culture might look or feel like. The

researcher takes the view that this has become a victim of extreme 'political correctness'. As a result, some would argue that blame should be avoided at all costs. There are however some very clear situations where apportioning blame is entirely justified. The use of a systems (rather than a person) approach to the management of an incident allows a clearer understanding of the root causes. This in turn facilitates a more effective resolution. It is the researcher's view that whilst a systems approach is being discussed more widely within the nursing professions, it is the person approach that remains the dominant method of management.

There has also been a wider interest in the concept of blame within society as a whole and it is an issue being addressed by many different groups in different settings for example teachers, social workers, police etc. Blame is also being used in the health context in a different sense, in that patients are blamed for their state of health e.g. blamed for developing cancer as a result of smoking or heart disease as a result of poor diet etc. Blame within a legal context relates to an individual's moral culpability for acts of omission or commission and provide us with yet a further set of circumstances in which blame may be defined and attributed.

6. THE LEGAL CONTEXT

[a] Nursing and the law

Nurses understanding of the law and how it affects their professional life has not played a prominent role in basic preparation for registration. In the preface to his book *Law For Nurses and Nurse-Administrators* in 1940, Speller points out that although some knowledge of law is expected of candidates for certain higher nursing qualifications such as the University of London Diploma, 'no book on law has yet been written for the nurse'. This spurred him to write a book for nurses. Young (1995) argues that 'Their knowledge still tends to be patchy but is now a topic that very much grabs their interest'. An understanding of the law is now part of the pre-registration and undergraduate programmes within the UK. Understanding duty of care is a fundamental part of an understanding of a legal perspective of nursing practice.

The differences between criminal and tort law are outlined by a number of authors in this field (for example Montgomery 1995). Criminal deals with a wrongdoing committed against society as a whole. Tort law deals with the relationships between individuals. To this end any study of law in relation to professional nursing practice is concerned with tort.

In order to determine whether an action has been deemed to be negligent, three basic questions need to be answered in the affirmative.

1. Does a duty of care exist between the two parties involved ?
2. Has the duty of care been breached ?
3. Has the breach of duty resulted in an injury ?

The first of these questions are readily answered. It is relatively simple to establish whether a duty of care exists. Within nursing any nurse who looks after a patient within an institution or within the patient's home clearly has a duty of care to that patient. The second question is more difficult to establish – i.e. did the professional fail in their duty of care. This brings into question the standard of care provided. Within English case law, the Bolam case in 1957 established the standard of care expected is that of any 'ordinary skilled doctor acting in accordance with the practice accepted by a responsible body of medical men skilled in that particular art'. (Bolam v Friern Barnet Management committee). Thus the standard of care any patient can expect is a reasonable one and not the 'gold standard'.

Within Scotland, the case considered as the leading authority is Hunter v Hanley 1955. This case predates Bolam and the language adopted by Lord Clyde suggests that the test relates to the course of action taken by any professional man of ordinary skill. McNair in 1957 however uses a different form of words and relates to the actions of a body of medical men. Whilst this may appear to be a straightforward standard against which other cases may be measured, Howie (1983) argues that standards adopted within England are different from those in Scotland. It is important to review these two cases and explore

Howie's conclusion that the two tests are different, indeed, to explore the view that the test in Scots law is more stringent than in English Law.

In *Hunter V Hanley*, Lord Clyde directed that:-

'To establish liability by a doctor where deviation from normal practice is alleged, three factors require to be established. First of all it must be proved that there is a usual and normal practice; secondly it must be proved that the defender has not adopted that practice and thirdly (and this is of crucial importance) it must be established that the course adopted is one which no professional man of ordinary skill would have taken if he had been acting with ordinary care.'

In *Bolam v Friern HMC*, McNair J directed that :-

'A doctor is not negligent, if he is acting in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art... merely because there is a body of such opinion that takes a contrary view.'

In *Hunter V Hanley* the test is that a doctor can be found to be negligent if it can be shown that the action taken is one in which no professional medical man of ordinary skill would take. In *Bolam V Friern* however the test is that a doctor cannot be found to be negligent if it can be shown that the action taken is one which a body of medical men would take. Hence, Bowie's assertion that the test for negligence is more stringent in Scotland than in England.

Other authors dispute this potential difference between the tests in England and Scotland. For example Norrie argues that if a Scots court was unable to establish that a common practice was negligent then it would be difficult to see that this would not be the case in England. In supporting this view it is noted that *Bolam* adopts the test within *Hunter* and two further cases cite two other cases which have adopted the same test i.e. *Whitehouse Vs Jordan* and *Maynard Vs West Midlands Health Authority*.

The third part of the test relates to the whether the injury was caused by the breach of duty. This is perhaps more difficult to determine. For example it may be evident that the patient has been harmed in some way but being able to form a causal relationship between the alleged breach and the sustained injury may be more difficult. Edozien (2001) comments that

‘In medical negligence action, it is in most cases easy to establish the existence of a duty of care. Where most cases fail is establishing a breach of that duty or in establishing causation.’

[b] Fatal Accident Inquiries

A fatal accident inquiry (FAI) is the Scottish equivalent of a coroner’s inquest. There are some significant differences between the two systems. The most notable is that the Coroner in England and Wales undertakes the investigation and acts as the judge whereas in a FAI the Procurator Fiscal undertakes the investigation and presents this to the Sheriff in whose Sheriffdom the death occurred. In drawing comparisons between the two systems Donald (1998) comments that

‘Like its English counterpart, the Fatal Accident Inquiry is a fact-finding not a faultfinding exercise and the terms of a determination can neither be founded upon, nor admitted in evidence, in a future action.’

As such it is unlikely that a FAI would be considered if there is any likelihood of any criminal actions.

Fatal accident inquiries are set up under the provision of the Fatal Accident and Sudden Deaths Inquiry (Scotland) Act 1976. The act came into force in 1977 and at the same time repealed the preceding Fatal Accidents Inquiry (Scotland) Act 1895 and the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1906. Under the provisions of the Act an inquiry can be undertaken following an untoward clinical incident resulting in death as it may be regarded as being expedient in the public interest. Such investigations are set up as a fact-finding rather than a faultfinding exercise. Sheriff Reith in her determination following the inquiry into the death of Sharman Weir comments

‘In my opinion a Fatal Accident Inquiry is very much an exercise in applying the wisdom of hindsight.’

In recognising the issues in relation to fault finding and blame (which is of particular relevance to this study) Sheriff Reith refers to *Black V Scott Lithgow Ltd* and the comments made by Lord President Hope in relation to role of a fatal accident inquiry

‘There is no power in this section [of the act] to make a finding as to fault or to apportion blame between any persons who might have contributed to the accident. This is in contrast to section 4(1) of the 1895 Act, which gave power to the jury to set out in its verdict the person or persons, if any, to whose fault or negligence the accident was attributable. It is plain that the function of a Sheriff at a Fatal Accident Inquiry is different from that which he is expected to perform at a proof in a civil action to recover damages.’ (*Black V Scott Lithgow* 1990 SLT 612)

In the course of the investigation the following sections are required to be outlined in the final determination: -

Section 6(1)(a): where and when the death and any accident resulting in the death took place.

Section 6(1)(b): the cause or causes of such death and any accident resulting in the death.

Section 6(1)(c): the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided.

Section 6(1)(d): the defects, if any, in any systems of working, which contributed to the death or any accident resulting in the death.

Section 6(1)(e): any other facts that are relevant to the circumstances of the death.

Whilst it is acknowledged that the process has been established in order to find the facts and not the fault, the requirement to report under sections (c) and (e) offers the Sheriff considerable scope to comment on any issues which may have emerged in the course of the evidence provided and that relate directly to the circumstances surrounding the death. As such these comments can be very helpful to organisations in identifying weaknesses,

which need to be addressed. However the negative side is that individuals may be singled out for particular criticism.

Within the data for this research study the determinations of forty-one FAIs are explored in some detail and therefore comments of their usefulness in relation to the management of untoward clinical incidents are reserved for that section. Levy and McRae (2004) however offer six main features of FAIs that make them an important part of the legal process.

1. You have the opportunity to hear evidence on oath from relevant witnesses. The notes of sworn testimony can be lodged in any following civil case to determine any change in position.
2. You can challenge unfavourable evidence in cross-examination and by adducing alternative sources of evidence.
3. You can recover important documentary evidence and have the opportunity to examine physical evidence, which may include the use of experts.
4. Issues of liability, fault and cause should in most cases become clear.
5. Any gaps or inadequacy in your civil should become clear or be capable of being dealt with.
6. Compared to any civil litigation the FAI is usually cheaper and more productive in recovering information.

Some of these points, at first reading, would suggest that they are contrary to an understanding of the function of an FAI. For example Issues of liability, fault or cause should in most cases become clear appears to contradict the view that a FAI is a fact finding rather than a fault finding exercise. However, essentially the point being made relates to the fact that such issues may be clarified within an FAI as opposed to this being the primary function of the inquiry.

[c] Summary

The precedents set in the courts provide the definitions and principles of clinical negligence. These have in the main been established through cases involving doctors although these principles would apply equally to nursing (and indeed other clinicians). Within Scotland, fatal accident inquiries provide a legal setting within which clinical

incidents that result in death can be examined in some detail in order to, as one sheriff noted

‘The purpose of any conclusions drawn is to assist those legitimately interested in the circumstances of the death to look to the future. They, armed with the benefit of hindsight, the evidence led at the Inquiry, the Determination of the Inquiry, may be persuaded to take steps to prevent any recurrence of such a death in the future.’ (Sheriff F Reith – Inquiry into the death of Sharman Weir 23rd January 2002)

The stated aim of any FAI is to establish facts and not fault. The systems approach to incident management adopts a similar philosophy. The NHS has identified this approach as the preferred way forward. It is therefore a legitimate form of enquiry to review the processes employed within a FAI and to identify whether such processes can be adapted for use within the NHS.

Part 2
The Study

Chapter III

METHODOLOGICAL ISSUES

BACKGROUND AND RATIONALE

This qualitative study explores qualified nurses' experiences and perceptions of the management of untoward clinical incidents using a phenomenological approach. Holloway (1997) describes such qualitative research as

‘.....a form of social enquiry that focuses on the way people interpret and make sense of their experiences and the world in which they live. A number of different approaches exist within the wider framework of this type of research, but most have the same aim : to understand the social reality of individuals, groups and cultures. Researchers use qualitative approaches to explore the behaviour, perspectives and experiences of the people they study. The basis of qualitative research lies in the interpretative approach to social reality.’

Polit et al (2001) describe the phenomenological approach as having ‘... its disciplinary roots in both philosophy and psychology (and) is concerned with the lived experience of humans.’ The authors go on to identify this approach as being closely related to the research tradition of hermeneutics. Hermeneutics ‘...uses the lived experiences of people as a tool for a better understanding of the social, cultural, political and historical context in which those experiences occur.’ (Polit et al 2001)

The data collection processes employed throughout this study involved the collation and analysis of national and local policy documents relating to the management of untoward incidents, an in-depth critical examination of the documentation relating to individual incidents, interviews with managerial staff, and interviews with those nurses and investigators involved in the individual incidents. The final area of investigation is an examination of the determinations of fatal accident inquiries undertaken and reported within the timeframe of the study.

The research process was undertaken in a number of stages. The first stage was an examination of policy documents and the documentation relating to past incidents. It examined:-

1. Who was involved in the investigation process
2. The nature of the clinical incident
3. The record of the investigation
4. The outcome of the investigation
5. The level of action taken

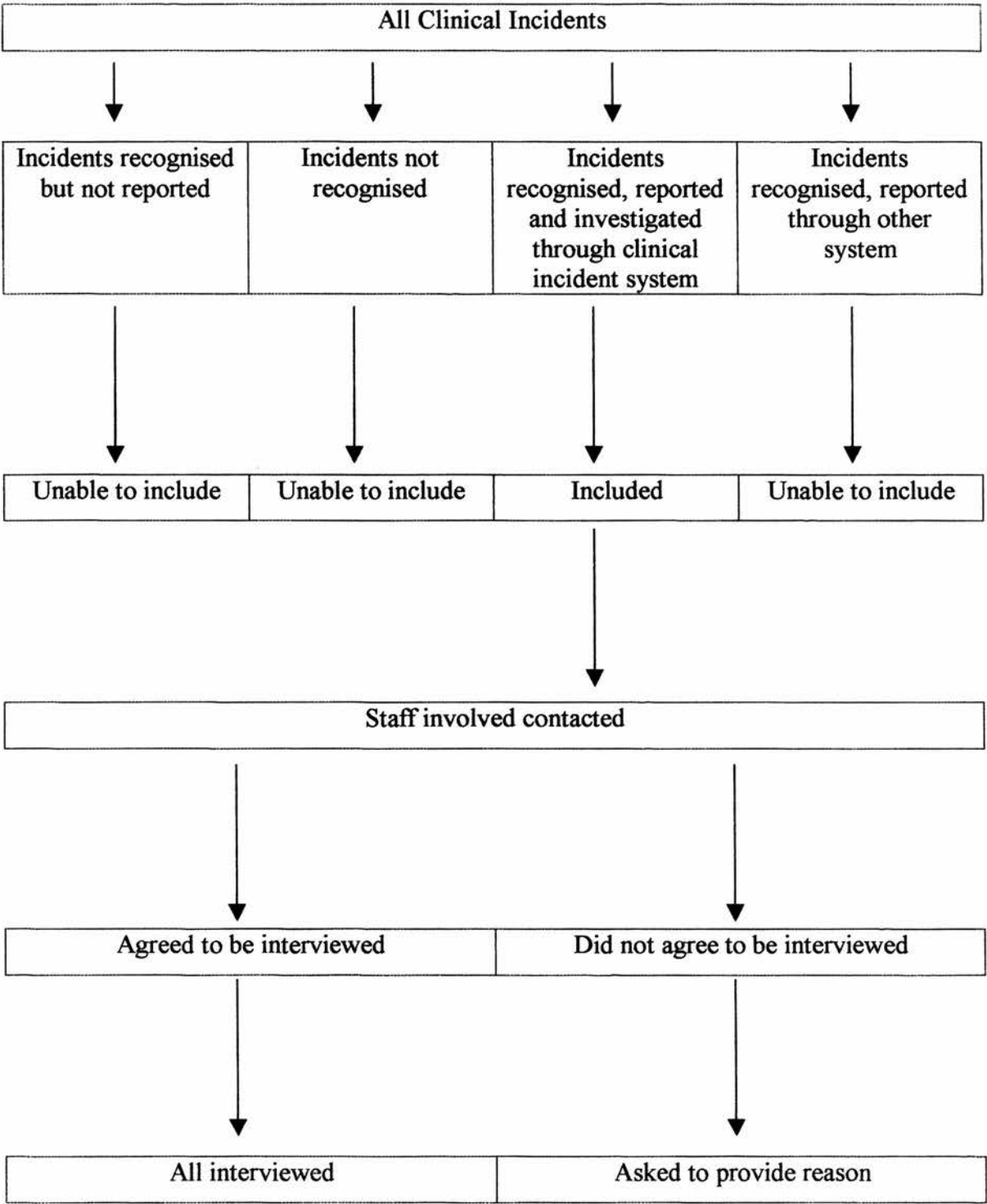
The second stage was a detailed exploration of a number of the investigations examined in the first stage. In particular the researcher investigated (1) the perceptions of the staff involved in the incident and (2) the perceptions of the individual investigating the incident

The research finally examined how the information gleaned and the lessons learned from the incident and the subsequent investigations are then used to inform changes in clinical practice, development of clinical risk strategies and the achievement of the principles of clinical governance. The research also examined a number of cases, which were the subject of a Fatal Accident Inquiry (FAI). The researcher examined whether the process provided a lead in the management of clinical incidents, which could then be employed at an organisational level. By the nature of such incidents this was a retrospective review of cases rather than a concurrent examination of the process. These determinations were obtained from the public records available through the court system. As these were in the public domain the issues of confidentiality were less restrictive. The FAIs were not restricted to those generated from a hospital environment.

The techniques were in the main qualitative techniques in order to obtain as much information as possible surrounding the incidents and how the key players felt the process was handled. In particular the research examined the perception of the apportionment of fault and whether the key players felt that the outcome was 'fair'.

SAMPLING PROCEDURES

Figure 1 Diagrammatic Representation of Process of Sampling



Morse (1991) proposes that the method of sampling in qualitative research must be both appropriate and adequate and goes on to define these as: -

Appropriateness: The degree to which the choice of informants and method of selection fits the purpose of the study as determined by the research question and the stage of the research.

Adequacy: The sufficiency and quality of data.

It is recognised that in order to meet the criteria for appropriateness and adequacy that the researcher must have a high degree of control over the composition of the sample. The figure outlined above demonstrates how the sampling was influenced and to a degree determined by the design of this study. It also demonstrates the control exerted by the researcher in determining the subjects in the final stage interviews. It is important to note that the clinical incidents included within the sample were only those reported through the organisation's clinical incident policy framework. At the beginning of the study this was managed through the organisation's nurse management structures. At the outset of the study it was recognised that the researcher may have had to select a cross section of incidents if there was a significant number of similar types of incidents (for example the study could have been dominated by incidents involving medication errors). This however was not the case as the reported incidents provided a broad range of different scenarios.

Having identified the incidents to be included within the study, the researcher was able to identify the members of staff involved and the role they played. Each member of staff was then contacted by letter with an information brochure and consent form, (Appendix 1 and 2) thus the willingness of subjects to become involved in the study determined the number and range of subjects involved in the second stage. The researcher also felt that the reasons why individuals did not wish to take part in the study could provide some fruitful data. Therefore, each subject was asked that if they decided not to take part in the study that they provide a brief explanation for this decision. It was also made clear to

subjects that they were free to withdraw from the study at any time throughout the process. This understanding of the reasons for declining and or withdrawing from the study are described by Polit et al (2001) as an integral part of any critique of a sampling plan for a qualitative study.

A number of incidents were excluded from the study. Current live investigations were excluded to prevent the research study being seen to be 'interfering' with a difficult and potentially stressful situation for those involved. Incidents that could have compromised the anonymity of the subject organisations were excluded. Incidents which were part of a formal legal process were also not included. These were excluded by the researcher in drawing up the research protocol and were ultimately excluded by the sampling process as such incidents were removed from this policy framework. These were managed under a different policy framework, implemented and managed in conjunction with the Central Legal Office (CLO). The CLO is the source of legal advice for all organisations within NHS Scotland.

DATA MANAGEMENT

Mason (1996) describes that within qualitative research, data are generated rather than collected. The generated data was managed according to the data source. Data from documents were managed via a system of paper and computer programme and disc. Semi-structured interviews were taped and then transcribed. All data were managed by the researcher in order to assure participants of their anonymity

Policy Examination

The first stage of this was to review the policy documentation relating to the management processes to deal with such incidents and investigations. The policy documents included those developed at a national level to guide practice across NHS organisations as well as those developed at a local level to guide practice within the subject organisation. As the research was conducted across a significant timescale it was recognised that policy development within this period was a dynamic process. This was particularly the case in the management of quality, clinical governance and risk management. Accordingly, it was important to acknowledge that different incidents may have been managed within

different policy frameworks. As such it was essential to relate any reported differences in the management of incidents directly to the policy framework within which it was investigated.

Retrospective Documentation Review

The research involved a review of all documents used in the management of a clinical incident. This included any formal recording documents (for example clinical incident report pro forma, RIDDOR etc.) as well as any statements provided by the individual involved in the incident and any witnesses. The package of documents also included the final report produced by the investigator. As the data were being collected any references which may identify individuals or situations were coded in order that anonymity may be assured. The researcher employed a number of techniques in order to ensure that the relevant data could be extracted from the documentation. The data required included clinical areas involved, nature of incident, any injury sustained, involvement of patients, process of investigation and the outcome of investigation.

Interviews with Investigator and the Investigated

The researcher interviewed, using a semi-structured interview technique, the key individuals involved in the investigation. These only took place where an investigation had been completed. The key individuals included the investigator, the individual under investigation and any witnesses called to the formal investigation. None of the investigations had led to an appeal against the decision made and therefore there was no opportunity to review the appeal process. Kahn (1957) [cited by Sullivan 1998] described an interview within a research context as 'a conversation with a purpose'. Sullivan identifies the advantages and disadvantages of using the interview in qualitative research.

Advantages

- It takes into consideration individuals who are unable or unwilling to write out long coherent answers.
- The most appropriate way to facilitate a participant within the project to express their experiences freely.

- Allows the researcher to assess 'latent content' of the interview such as facial expressions, voice intonation and body language.
- To seek clarification were necessary.

Disadvantages

- Interruptions either by telephone or unexpected caller.
- Insufficient time allowed for the interview.
- 'Stage fright on the part of the participant.
- Failure to ask the questions in a logical manner.
- Interviewer resorting to teaching, preaching or counselling.

Other considerations to be taken into account by the researcher related to consent from participants, confidentiality, the time, place and length of the interview, withdrawal from the interview and the method of recording the interview. The researcher addressed these as follows

Consent: Subjects were asked to return a completed consent form to the researcher indicating their willingness to take part in the study or to provide a brief explanation for their decision not to take part.

Confidentiality: This was assured as the organisation was not identified by name, the individuals involved would not be identified and the researcher was the only individual with access to the coded information.

Time place and length of interview: These were, in part, determined by each of the research subjects. The researcher agreed to arrange the meetings at a time and place convenient to each subject.

Withdrawal from Interview: It was reiterated to research subjects that they could withdraw from the process at any time.

Method of recording: The research subjects were made aware that the interview would be recorded (audio recording only) and that the researcher would transcribe the interview ensuring anonymity.

Review of Fatal Accident Inquiries

The researcher reviewed documentation involved in the process of a Fatal Accident Inquiry. There were no fatal accident inquiries relating to the subject organisation within the timescale of the study. The researcher therefore reviewed the determinations of FAIs across Scotland between 1999 and 2004. An explanation of the role and function of an FAI is provided as part of the literature review. The data were extracted from the Scottish Court Opinions. In total 41 determinations were examined.

DATA ANALYSIS

All data was analysed by the researcher as another measure to assure the participants of their anonymity. A number of authors have identified different ways of undertaking an analysis of qualitative data (Polit et al 2001, Holloway 1997, Morse 1991). The researcher employed a process, which was in effect a hybrid of these different approaches to qualitative data analysis. The nine-step process is: -

1. Ordering and organising the collected material from both the documentation review and the semi-structured interviews.
2. Re-reading the data - the semi-structured interviews were taped and transcribed.
3. Breaking the material into manageable sections.
4. Identifying and highlighting meaningful phrases.
5. Building, comparing and contrasting categories in particular the comparison in the process between different units within an organisation.
6. Looking for consistent patterns of meanings.
7. Searching for relationships and groupings categories together.
8. Recognising and describing patterns and themes and typologies.
9. Interpreting and searching for meaning.

VALIDITY & RELIABILITY

Younge & Stewin (1988) argue that within qualitative research validity and reliability are 'misnomers'. Maxwell (1996) however argues that the concepts are valid in qualitative research but uses differing procedures in order to demonstrate that the study is both

reliable and valid. Brink (1991) states that 'when a researcher uses a single data collection instrument only once on single individuals questions are often raised about the reliability and validity of the research'. By using several data collection methods the researcher believes that the validity and reliability of the research can be assured.

Validity

Internal validity within the study is demonstrated by providing evidence (quotes from interviews etc.) to support statements made within the research project. By achieving this, the research is then open to public scrutiny. External validity is much more difficult to establish as the research is specific to a very defined area of research and context. It is important however to establish the research's trustworthiness through the reflection of the ideas and perceptions of the participants. To achieve this degree of validity the transcripts from the interviews were returned to the subject for any additions / omissions and corrections they felt were necessary to ensure that their views were being fully reflected in the data.

Reliability

The concept of reliability is difficult to apply in its strictest term to qualitative research. Reliability in quantitative research is designed to ensure that the techniques used within a study can be replicated in another project and produce similar findings. Holloway (1997) argues that "this consistency is difficult to achieve in qualitative research because the researcher is the main research instrument." Therefore as the relationship between researchers and participants is unique qualitative research cannot be replicated in exactly the same way as quantitative research studies. It is however important that an audit trail is produced in order that the process is open to scrutiny. This has been achieved within this study by clearly defining the process of gathering the data and having the data checked by the subjects who were interviewed.

LIMITATIONS & DELIMITATIONS OF STUDY

The limitations (shortcomings and restrictions) of the study are similar to those attributable to all qualitative research. These relate to the generalisability of the findings. The particular limitation of this study is that it concentrates on units within one

organisation. The original research proposal attempted to address this by involving more than one organisation. Unforeseen problems relating to access prevented the research being undertaken in the additional organisation of choice. Delays in reaching a final decision prevented an alternative organisation being identified and utilised within the study.

The delimitations (boundaries) of the study is that it only included incidents involving qualified nurses, only those involved within the organisations under investigation and only reviewed the Fatal Accident Inquiries which have been completed within a five year period leading up to the date of agreement received from the Chief Executives of the respective organisations.

ACCESS

The researcher is a senior manager within an NHS Trust. It was recognised that access to current and historical data would require the permission of the Chief Executive at the outset. There would appear to be no apparent reason why this would be refused. Similarly the researcher would have easy access to staff involved in order that face-to-face interviews could be conducted. In approaching organisations and individuals for access to information assurances of complete anonymity would be guaranteed as only the researcher had access to documentation supplied and the transcripts of any interviews. Similarly through the researcher's networks within both the local and national health service there were no perceived difficulties in obtaining access to other healthcare providers in order to obtain comparative data should this be felt appropriate.

As the study progressed significant problems were encountered relating to access to one of the organisations. These problems are explored further in this chapter and a more detailed commentary on the wider issues are contained within Chapter X.

ETHICAL CONCERNS

In developing the proposals for the research, it was felt that as the study did not require access to patients or their records nor did it require access to staff's personal information,

there would be no requirement for ethical approval via the local ethics committee. Following concerns raised by one of the study organisations this decision was reviewed and an application was submitted. The view of the ethics committee was that the study did not require ethical approval.

It was however recognised that there were a number of ethical issues, which need to be borne in mind throughout the study. The main ethical concern surrounded the need to assure anonymity of the organisations, incidents and the individuals participating in the study. This was assured by the removal of any unique identifiers within texts and the guarantee to interviewees that the interviews would be coded and only the researcher would know and have access to the codes. Where required, further security measures were taken to assure anonymity. These included

- The use of pseudonyms, which do not resemble the real names of those, involved within the research.
- Ensuring participants are not identified by gender, age or professional staff group (i.e. staff grade or areas of working)
- Specific locations (including the organisations used within the study), which may be identifiable, were excluded in any narrative.

Holloway (1997) identifies a variety of general ethical considerations, which must be made in development of qualitative research. Those which are particularly pertinent to this study include: -

- The researcher's 'sensitivity and diplomacy' whilst dealing with professional colleagues.
- Considerations in obtaining informed consent at the outset of the study.
- Potential compromising of the participant anonymity due to the detailed nature of the research.
- Potential conflict between the roles of investigator and professional within an organisation.

- Understanding by the participants of the role of the researcher as investigator or professional.
- Potential for participants to become 'distressed' during interviews.
- Potential for 'empathy' to introduce assumptions and inaccuracies within the research.

The researcher acknowledged the potential for the above situations to present ethical dilemmas within the research and these were minimised by the design of the methodology, data collection and data analysis methods.

As the researcher is a healthcare professional within the area of study, the issues of 'insider research' must also be included as part of the ethical considerations. Hewitt-Hewitt-Taylor (2002) identified some of the advantages and disadvantages of insider research but concludes that on the whole that insider research provides an added dimension to the quality of the qualitative data that are collected. This view echoes the experiences of McEvoy (2001) who concludes in a review of interviewing colleagues as part of a research project:

'Shared experience may act as a catalyst that helps to generate new avenues of experience by opening up and extending the depth of a discussion.'

Whilst accepting that there are a number of common features of an interview between colleagues and one between anonymous interviewers there are a number of issues which need to be taken into account: -

- The nature of the insider's perspective.
- The dynamics of interviewing in the context of an ongoing relationship and presentation of findings.

McEvoy also outlines the similarities in the ethical issues encountered through interviewing a colleague and those encountered by ethnographic researchers conducting fieldwork.

Sullivan (1998) identifies some of the issues to be considered when undertaking sensitive interviews. The examples cited relate to research into bereavement in same-sex relationships. The research undertaken within this study is also very sensitive in that we are effectively asking nurses to 'relive' a traumatic experience, which may in some instances have had a devastating effect on patients.

The researcher secured the assistance of a clinical psychologist external to the organisation used within the study. This provision was made to ensure that should the process of taking part in the study prove to be overwhelming for any individual subject, they could have access to a professional who could assist them to work through any particular unresolved issues. In discussion with the psychologist, it was agreed that any request would be made directly to the psychologist and would not involve the researcher. The psychologist involved proposed that such sessions would be approached using techniques similar to those used within post-traumatic counselling.

THE ORGANISATIONS

The two organisations involved within the research are National Health Service Trusts within Scotland. A very brief description is given to provide some understanding of the size, nature and structure of the organisations. The lack of detailed information is deliberate in order to maintain the anonymity of the two organisations. This was part of the agreement with the chief executives in obtaining access to the data. During the completion of the research, NHS Trusts within Scotland were dis-established and these organisations no longer exist as legal entities. They became instead operational divisions of a unified health board.

Trust A: A large teaching Trust with several general hospitals and specialist hospitals all of which had training status. The clinical care within the Trust is managed through a number of directorates each of which has a number of related clinical sub-specialties.

Trust B: A moderate size Trust, which also has a number of general hospital and specialist units. The district general hospital is regarded as a teaching district general hospital. Like Trust A this Trust is also managed through a number of clinical directorates.

PROBLEMS RELATING TO ACCESS

The researcher made the initial approaches for access to the data directly to the chief executive of each of the two organisations. Not surprisingly these were then referred to the directors of nursing. Trust A posed a number of questions with regard to the study relating to some recent organisational changes that may have influenced the outcome of the study. Following a meeting with the director of nursing, approval for access to the requested data was granted. Trust B responded indicating that they were happy for the study to proceed.

From a logistical standpoint it was felt that the initial stages of data collection should be based within one organisation at a time, therefore, the data was initially collected from Trust B. However during the data collection within Trust A, a number of concerns were raised with regard to the methodology and a meeting was requested between the Trust's senior nurse for research. Following extensive discussions it was agreed that ethical approval should be sought for the study. The rationale being, that since the initial approval a new research governance framework had been introduced which insisted that all health related research should have ethical approval. An application was made to the local ethics committee, which responded by indicating that in their view the study did not require ethical approval and that if managerial access was agreed then the study could proceed.

The committee reported its findings to the relevant executive directors in the two organisations. Trust A expressed concern and surprise at this decision and were unsure how to proceed. The researcher met with the senior nurse and the research manager to discuss how to deal with their concerns. It was felt that an honorary contract would have to be awarded to the researcher. This was not felt to be problematic. The organisation's representatives had a number of concerns about the researcher's access to sensitive data relating to employees. A number of potential means of obtaining the data were explored however each was regarded as being flawed from the organisation's perspective.

Trust A, required that individuals within the organisation be contacted to agree to have the data relating to an incident in which they were involved released to the researcher.

This presented a number of problems:-

- If an incident involved a number of individuals and all but one gave consent this would not be provided to the researcher.
- The methodology suggested by the researcher offered the staff member an opportunity not to take part in the study if that was their preference. This would still allow the research to use the details of the incidents but not follow up issues with an individual.
- The selection of the incidents for investigation would be affected by the willingness of the individuals to take part rather than be a part of the management information available within the organisation.

The researcher then suggested an alternative methodology. The information could be provided in an anonymous format to the researcher who would then identify the incidents, which he would like to discuss further with the staff involved. However, the organisation's data systems could not provide information in this format. It was then suggested that someone from the organisation could remove the names manually. This was not accepted by the organisation, indicating that they would not be able to release staff time to undertake this exercise.

These difficulties were discussed with the project supervisors who agreed that the suggested methodology by the organisation was likely to introduce a bias into the type of incidents, which could be investigated. The original methodology allowed for individuals who had been involved in an incident not to take part in the interviews. It still however allowed the researcher to have details of the incident and how it was managed which was an integral part of the study. The new methodology would not have allowed the researcher access to the incident itself, despite previous access approval from more senior and accountable individuals with executive roles within the organisation.

Given the likely introduction of a bias into the data collection it was agreed that the research should not include data from Trust A. The issues raised by Trust A were discussed once again with Trust B who felt that the study had a robust methodology and was assured that as individual members of staff had an opportunity to decline to take part in the study, there were sufficient safeguards for the individuals whom they had a responsibility to protect.

In both organisations it was once again reiterated that there was no requirement for the researcher to access either a patient's medical records or a member of staff's personal file. The researcher only required access to the management information retained relating to individual incidents. This process took almost two years to work through and a significant delay in the timescale for the completion of the study was inevitable.

END NOTE

In concluding the chapter on methodological issues it is worth reflecting two main areas of concern emerged during the study.

Firstly, as described above, the initial research proposal outlined the data collection to be completed using two NHS organisations. The process was therefore based on this premise and access to the organisations sought. Having obtained permission from the chief executive's office from both organisations this proved to be more difficult in one of the organisations. Following lengthy discussions with the relevant more junior staff it

was felt appropriate to withdraw from this area of the study and to concentrate the research on the organisation that had agreed access and saw no reason to alter the original decision. The process and eventual outcome of the debate was frustrating for the researcher but on reflection there is little to suggest that it materially affected the data generated. There would have been a greater pool of nurses and managers who would have been approached to take part in the study but there is nothing to suggest that the response rate to the request would have been any greater and that the responses from the interviews would have been significantly different. However it is perhaps worthy of some discussion as to the ethical questions that could be raised with the organisation in light of their apparent unwillingness to allow access. Ashcroft [In Tingle](2002) presents the ethical issues in relation to nursing research and argues that there is a strong ethical element in nursing research as there is in nursing practice and declares that

‘...attention to the core principles of good nursing – respect for dignity and autonomy for patients, beneficence, non-maleficence, justice and integrity – will remain essential. The best research and best practice in research embodies and promotes these principles.’

As such he argues there is a duty to benefit others and taking part in ‘socially useful’ research is one way of doing that. It could be argued that it is unethical to act as a barrier to such socially useful research. The situation is made even more frustrating and in a sense ‘sad’ by the fact that the main barrier to this nursing research was another nurse.

Secondly, the number of nurses who agreed to take part in the study was relatively small and not as high as hoped. Although the study is qualitative in nature and therefore not concerned with the statistical importance of the number involved, it is worth commenting on the number of participants. Given the very sensitive nature of the study in that it aimed to discuss a traumatic event within a nurse’s professional career and the voluntary nature of taking part then it could be suggested that it may not have been surprising if no one agreed to take part. Fortunately that was not the case. There is also no evidence to suggest that if the number had been greater that the issues raised as part of the interviews would have been significantly different nor that the range of incidents would have been any

greater. (Holloway 1997) recognises that the sample size in this type of qualitative study tends to be small. Therefore, the research is presented with the view that there is nothing to suggest that the group of nurses and managers involved in the study were not a reasonable cross section of staff either from this organisation or any other NHS establishment. It is perhaps worth noting that a number of subjects approached did not take the time to respond despite a request from the researcher to provide a brief response as to why they would prefer not to take part in the study. The point made by Ashcroft that taking part in socially useful research where there is no cost to the individual applies equally to this group of professionals.

Chapter IV

POLICY

CHANGES IN THE POLICY CONTEXT

“Clinical risk and litigation management strategies have also been developed nationally, along with a number of health quality initiatives, which have introduced a whole new set of ‘buzz phrases’ such as clinical governance, control assurance, clinical risk management, patient empowerment, reflective practice, evidence based healthcare and life long learning.” (Tingle 2002)

During the period of the study, a number of different major policy developments were introduced within the NHS impacting on the management of untoward clinical incidents. As such it is important in analysing the data collected and generated during a period of such significant change that these are acknowledged and understood. The period also saw a number of initiatives on how nurses and nursing practice developed as part of the multidisciplinary team as well as in a uni-professional sense. The expected outcome of such policy developments, professional changes and political imperatives is a much more effective approach to the management of untoward clinical incidents.

POLITICAL CONTEXT

Scottish Parliament

The development of the Scottish Parliament and the devolvement of health to the Scottish Executive has seen some noteworthy changes in the way in which the health services are managed. There is a danger of assuming that initiatives within the Scottish NHS are nothing more than ‘tartanised’ versions of the initiatives in England and Wales. Perhaps the starkest contrast is in the debate around central control and local control. The development of Foundation Hospitals within England and Wales is a demonstration of the government’s desire to see health services being managed locally and free from influence of Department of Health ‘interference’. In Scotland however, the abolition of NHS Trusts and the formation of 15 Unified Health Boards and a suggestion that this number is reduced, demonstrates a much more centralist approach to the management of

health services. NHS Scotland also has a number of special health boards dealing with very specific operational areas, for example the Scottish Ambulance Service and the State Hospital. This difference in approach within the systems offers a unique opportunity to assess the impact of the two different approaches to managing health services. Arguably there are too many variables to make meaningful comparisons however there may not be an opportunity in the future to undertake such a study.

Other areas of development are more closely related to the issue of incident management. For example whilst there are no comparable organisations to NICE (National Institute of Clinical Excellence) and CHI (Commission for Health Improvement) in Scotland, the bringing together of several different organisations related to clinical quality and effectiveness under one organisation NHS Quality Improvement Scotland (NHSQIS), acknowledges the need for a national approach to setting and assessing clinical and non-clinical standards. NHS Quality Improvement Scotland was formed on 1st January 2003 as a result of the amalgamation of: -

- Clinical Standards Board for Scotland (CSBS)
- Scottish Intercollegiate Guidelines Network (SIGN)
- Nursing and Midwifery Practice Development Unit (NMPDU)
- Clinical Negligence and Other Risk Indemnity Scheme (CNORIS)
- Clinical Resource and Audit Group (CRAG)
- Scottish Health Technology Board for Scotland (SHTBS)
- Scottish Health Advisory Service (SHAS)

The organisation outlines its purpose as

“...to improve the quality of healthcare in Scotland by setting standards and monitoring performance, and by providing NHSScotland with advice, guidance and support on effective clinical practice and service improvements.”

The initial focus of this organisation related to clinical standards and in particular standards required for cancer care. The Clinical Standards Board for Scotland developed a set of generic clinical governance standards in January 2001. Around the same time the company commissioned by the Scottish Executive Health Department to manage the Clinical Negligence and Other Risk Indemnity Scheme (CNORIS), Willis Ltd, developed risk management standards. The development of NHS QIS saw these two elements being brought together under HDL (2003) 29. The result was the development of a set of healthcare governance standards which at the time of writing were in draft form and available for comment.

One part of the standard relates to the management of adverse events. However, there appears to be a very broad interpretation as to what constitutes an adverse event. Consequently, criteria relating to the management of complaints and claims are identified alongside actual clinical incidents. The definition of an adverse incident used within the document is: -

‘Any event or circumstance that could have or did lead to unintended or unnecessary harm, loss or damage to patient, public, staff or organisation.’
(NHS QIS 2003)

It is clear that this definition is intended to cover many different incidents (actual or avoided) and in doing so almost makes it unusable in relation to how organisations manage any aspect. For the purposes of this research it does not help to define how organisations should manage clinical incidents. This situation is further complicated by the use of another term i.e. adverse event, which the document defines as: -

‘Any occurrence which is not routine, and which causes physical or psychological harm, loss or damage.’ (NHS QIS 2003).

Again this is very broad and given the similarity to the definition of adverse incident then it is not unreasonable to question the need for a separate definition. As organisations are expected to meet the criteria set out in the document it is likely that they will look to these standards in order to inform the development of a framework within which such

policies and procedures should be implemented locally. However, the lack of specificity in the terms used and the method in which organisation will be measured make it very difficult for organisations to appreciate fully either what is expected of them or how they will be assessed against the criteria. Whilst it is recognised that the standards are at this stage draft and are being circulated widely for comment and consultation it is perhaps worthy of note that the issue of patient safety and how the NHS manage untoward incidents has been apparently handled so poorly by the organisation established to oversee how well healthcare providers are able to manage such situations. The draft document makes reference to some of the relevant literature but this could be more extensive. One of the sections within the draft document is headed 'Evidence Base for the Draft Standards for Healthcare Governance' and contains 42 references. However, very few of the references could be regarded as 'evidence' and would more accurately be described as 'rationale' in that many are Scottish Executive and other bodies' policy documents, consultation documents, Acts of Parliament etc. Given that NHS QIS now includes the Scottish Intercollegiate Network Guidelines (SIGN) it is surprising that its system for grading evidence has not been adopted across the entire organisation. This would help to improve the credibility of these standards and demonstrate that managerial practice is becoming more evidence based, in that way the clinical practice is now expected to become.

Given the body of knowledge which has been gathered in relation to untoward incidents and how these can be managed to maximise the learning opportunities for organisations, it is surprising that these have not been referenced. It is also noted that, with the exception of the NPSA, none of the Department of Health's documents, which relate to the management of untoward incidents, are included within the list. There may be a number of explanations for this including the need for NHS Scotland to be seen to be 'different' from its counterparts in the rest of United Kingdom or that these were not regarded as adding value to the thinking. Whatever the explanation the result is that there are inconsistencies between the four countries, which in turn make it difficult to identify meaningful comparisons on the number and types of incidents, how these have been managed and the dissemination of lessons learned. This can be particularly problematic

when it relates to how members of staff who are involved in untoward incidents are managed. If there are significantly different policies across each country this makes the work of professional bodies which function at a national basis more difficult. It is also noteworthy that the draft healthcare governance standards do not include criteria in relation to research governance.

National Patient Safety Agency

As part of its 'frequently asked questions' (FAQ) section of its web site the National Patient Safety Agency describes itself as follows:-

'The National Patient Safety Agency (NPSA) is a Special Health Authority created to co-ordinate the efforts of all those involved in healthcare, and more importantly to learn from adverse incidents occurring in the NHS. As well as making sure that incidents are reported in the first place, the NPSA is aiming to promote an open and fair culture in hospitals and across the health service encouraging doctors and other staff to report incidents or near misses when things almost go wrong.' (NPSA 19th June 2002)

This organisation has no specific focus within Scotland, however its recommendations etc. are provided to NHSScotland for its consideration. For example its first 'warning' related to the use of strong potassium hydrochloride at ward and department level and the recommendations have been adopted within the Scottish Health Service.

The NPSA's most significant development has been in the formation of a framework for developing a safe organisational culture and environment. This not only includes a seven-step approach to improving safety but the formulation of a national reporting system in order that national trends in untoward clinical incidents (or what NPSA has termed Patient Safety Incident) can be demonstrated and action initiated where appropriate. Woodward (2004 (a), 2004(b), 2004(c)) outlines in some detail the seven-step model. The earliest reports in relation to the reporting and recording of such events received significant criticism from both lay and professional press, the former accusing the

Department of Health and more specifically the Health Secretary, of attempting to suppress the report which illustrated a level of incidents higher than was anticipated. The BBC reported that

‘...a storm has erupted over claims that Health Secretary Alan Milburn tried to prevent the release of the figures to avoid creating alarm among patients.’ (BBC 18th June 2002).

The report which was being cited was the outcome of a pilot study into the use of a central recording mechanism for adverse incidents and was reported as

‘The first-ever detailed study of “adverse incidents” in NHS hospitals has found thousands in just a handful of trusts over a six month period.’ (BBC 18th June 2002)

The joint Chief Executive of the NPSA sought to minimise the impact of the adverse publicity by indicating that

‘One of the major issues the pilot has revealed is the difficulty in providing the accurate information required by the NPSA. We are committed to publishing full figures as soon as the further analysis is complete.’ (BBC 18th June 2002)

Sir Liam Donaldson also attempted to fend off criticism of the report by commenting

‘What the pilot study has told us is staff are willing to report their errors if they think the information that they give might help a future patient and that it is very very good news.’.... ‘the less good news is we had a lot of technical problems. Some of the staff found the form too complicated. We have to go back to the drawing board on some of these problems. We are looking at ways of solving that before it goes nationwide...’ (BBC 18th June 2002)

Many of the issues however related to the process of recording incidents as well as a lack of clarity in how the system should be used by practitioners. There was also little or no attempt to ‘grade’ the incidents and as such a death was no different from a bandage being applied incorrectly. The lack of specificity in relation to the type of incidents

makes it more difficult to quantify those incidents which caused the patient harm and the degree of harm caused.

Clinical Governance

The term clinical governance was introduced in the 1997 White Paper relating to health service reforms. For the first time there was an overt recognition that chief executive accountability for clinical quality had equal status within to corporate governance and sound financial stewardship. Miller (2000) notes that this concept was described by the then health minister for Scotland as 'corporate accountability for clinical quality' and also draws together the reaction to this concept of many medical nursing and managerial organisations.

Within any organisation's clinical governance framework the issues of risk management and the management of untoward clinical incidents needed to be addressed and this prompted significant changes in how clinical incidents should be handled. The introduction of clinical governance also coincided with the revelations from the Bristol Children's Hospital which brought into very clear focus the issues of poorly performing clinicians, the reporting and recording of incidents, the organisation's response to such events and the management of individuals who found themselves within this nightmare scenario.

Clinical risk management as a formal process developed from this initiative. Some clinicians would argue (correctly in some instances) that risk management was not a new concept to clinical practice and was something practiced each and every time a patient came into contact with a member of the clinical team. However these new processes required that organisations had to review how clinical services were being delivered within the totality of a clinical environment as opposed to the weighing of relative risks to an individual patient of specific treatments or interventions. Almost inevitably this brought to the fore the issues of blame and the prevailing blame culture, within the NHS as a whole. This view was fuelled further by a number of high profile cases whereby clinicians were penalised for the outcome of incidents, which may or may not have arisen

as a result of an act of omission or commission on the part of the individual. Such penalties ranged from suspension from duty (sometimes for very extended periods), dismissal from their post and in some instances legal action.

MEDICO-LEGAL CONTEXT

It is perhaps not surprising that medical legal issues have become more prominent within the dynamic and more risk-laden environment, described above. As a result the concept of blame and how it is apportioned has become a subject of particular interest and as such generated the development of this research study. The work of some prominent authors in the field of clinical incidents was becoming more widely quoted both from within health spheres as well as from other sectors. Such authors included Leape, Brennan, Vincent, Reason, Merry and McCall Smith. From these writings we have developed a clearer notion of blame and how it should be handled and these have been instrumental in the development of new policies and procedures within which clinical incidents should be managed.

Making Amends

Within a consultation document entitled 'Making Amends' the Chief Medical Officer from the Department of Health outlines a number of different proposals to reform the approach to the management of clinical negligence within the NHS. There are a number of different proposals, which are established in order to create a climate, where: -

- Risks of care are reduced and patient safety improves because medical errors and near misses are readily reported, successfully analysed and effective corrective action takes place and is sustained.
- Remedial treatment, care and rehabilitation are available to redress harm and injuries arising from healthcare.
- Any financial compensation is provided fairly and efficiently.
- Payments of compensation act as financial incentives on healthcare organisations and their staff to improve quality and patient safety.
- The process of compensation does not undermine the strength of relationship between patient and healthcare professional.
- Different entry points to expressing complaints and concerns about the standard of care are well co-ordinated and well understood by the public and healthcare professionals.

- The system of compensation is affordable and reasonably predictable in the way it operates.

In relation to this study it is the first of these areas that is of particular interest. Arguably the second already exists in the sense that healthcare professionals will on the whole undertake all appropriate actions to ameliorate the effects of any untoward clinical incident. Given the issues reported within the literature and further expressed by subjects within this study and explored within Chapter VIII, there are a number of barriers to the timely reporting of clinical incidents and near misses. The consultation paper explains how it is proposed to improve the situation. The CMO suggests that: -

- Statutory provisions would be introduced to encourage openness in the reporting of adverse events. This would encompass: -
- A duty of candour requiring clinicians and health service managers to inform patients about actions which have resulted in harm.
- Exemption from disciplinary action for those reporting adverse events or medical errors (except where there is criminal offence or where it would not be safe for the professional to continue to treat patients).
- Legal privilege would be provided for reports and information identifying adverse events except where the information was not recorded in the medical record.

As a consultation document this has attracted considerable comment from a wide variety of different organisations. These include professional bodies, healthcare providers and organisations representing the interests of patients.

NURSING

Tingle recognised that there had been a number of changes within the legal environment of the new NHS and this coupled with changes within nursing practice required a rethink of approaches.

‘Avoiding health litigation has become a national priority and quite rightly so. At the same time nurses are expanding their professional role and are doing more. This is all taking place within an increasingly litigious working environment. Hence knowledge of the legal aspects of the health

care environment has become very important as nurse try to understand their professional and legal accountability.' (Tingle 2002)

Whilst this observation is true and one which will be recognised by many nurses within Scotland it could be argued that there has been little at a national level which acknowledges such changes and provides professional leadership as to how clinical nurses and nurse leaders can influence the design and management of risk management processes as they relate to nursing practice.

In response to an earlier call by the Chief Medical Officer in England for ideas in dealing with clinical negligence claims, the Royal College of Nursing identified from its own research that

- i. There is an unhelpful tendency by some employers to suspend the nurse immediately on receipt of a complaint or concern raised by a patient.
- ii. Nurses are often banned from communicating with colleagues and from attending the workplace during the investigation, notwithstanding the often-glib remark by management about 'innocent until proven guilty.'
- iii. The fact of a complaint and the decision to suspend are often communicated in an insensitive manner, and the removal of the nurse from the premises can be very distressing.
- iv. Investigations may take inordinate lengths of time to be completed.
- v. There is a lack of consistency in decisions to suspend.

In this response there are no references cited so it is difficult to assess the status of the 'research' referred to in this letter. However some of these issues will be explored further in Chapters VII and IX, where in the examination of a number of clinical incidents within an organisation and through the interviews of a number of staff involved in the management of clinical incidents there is are no issues with regard to suspension. Within the fifty-one incidents examined in great detail none of the nurses (or other clinical healthcare professionals) was suspended from duty. This would seem to be a significantly different experience from that described by the RCN. Within the same submission to the Chief Medical Officer the RCN goes on to suggest a number of strategies to deal with these issues, including

- i. Guidelines for managers about the use of suspension
- ii. Consideration of alternative strategies for keeping the nurse (or other health professional) at work.
- iii. Reconsideration of the ban against communicating with colleagues / friends during the suspension; training for managers in communicating complaints, decisions to suspend and so on.
- iv. Better support and information to staff during the course of the suspension.

Nursing organisations continue to provide input into the development of strategic policy at a United Kingdom level. There is little in the way of specific policy developments in relation to nursing and arguably this is due to the fact that the issues relating to the management of clinical errors are not fundamentally different between healthcare professional groups. However, as stated earlier within a devolved situation within Scotland there is corresponding input from nurses and nursing.

THE ORGANISATION'S POLICY DOCUMENTS

During the time period this study was undertaken the policy documents relating to the management of clinical incidents were reviewed and developed on a number of occasions. This reflected the dynamic nature of the area of study during the study period. This was in part due to the nature of the organisation and some of the key individuals within the managerial structures as well as the external requirements of the policy makers for NHS Scotland. As such it was important to ensure that all incidents were reviewed with the policy framework in place at the time of the incident. This was an important element in understanding the wider political and social context in which decisions could be reviewed. During the same time frame similar difficulties were being experienced in another area under investigation – the issues relating to the provision of consent for retention of human tissue. In this problem more recent thinking and understanding of the issues involved were being applied to clinical practice, which took place several decades earlier. Clinical practice was therefore 'judged' against different standards and within a different policy framework from that in which it was conducted.

The earlier versions of the policy were part of the wider policies relating to the management of accidents and incidents. A sub-section of the policy related to how clinical incidents should be managed. This was in the main directed at nursing staff but should technically have related to all clinical incidents. There was also evidence that there existed a different policy sponsored by the pharmacy staff relating the management of medication errors. There was a forum within the organisation's structure to formally sign off policies but there appeared to be other means by which policies became part of the functioning within the organisation with no evidence of formal approval from the appropriate committee within the organisation. Accordingly medication errors had the potential to be managed through different policies relating to incidents, health and safety, disciplinary and medicines management. Clearly the potential for confusion is significant as well as inconsistency between different parts of the organisation in managing similar incidents. The lack of consistency also results in a difficulty in managing a central mechanism to quantify such incidents.

In the most recent version, the policy documentation seeks to set out the overall principles within which the incidents are managed.

'The reporting, recording and investigation of accidents and incidents should be viewed positively by staff. The intention is to learn from these incidents and ensure that shortcomings are identified, improvements are implemented and ensuring that the chances of a repeat incident are minimised.

The Trust supports a positive, non-punitive reporting system with the aim being that any investigation will aim to establish the cause of the incident rather than apportioning blame. Any further actions against an individual would only occur in case of malicious acts or omissions, criminal or constitute serious professional misconduct or knowingly failing to follow Trust procedures. (Subject Organisation's Incident Policy, October 2002).

The policy statement is signed by the Chief Executive in order to demonstrate the commitment of senior management. The policy document clearly uses the national policy framework as a guide to the content of this local policy. This includes definitions and the

incident-grading matrix, which has been developed from a number of different sources and is recommended by the National Patient Safety Agency.

The new policy within the organisation was being implemented as the data collection processes were being completed and therefore there is limited evidence as to its effectiveness. However, whatever evidence was available from the actual clinical incidents and the staff interviews is explored within the relevant chapters. It is noted that the changes incorporated within the new policy guidance relate to initiatives from other parts of the United Kingdom. Such policies and their effectiveness we would expect to be assessed by NHS Quality Improvement Scotland using the draft standards described earlier.

SUMMARY

At a national level and subsequently at organisational level there have been a number of alterations to the policy documents utilised in the management of clinical incidents. These have in part been influenced by the wider political context. There is an observed lack of co-ordination between the health systems in different parts of the UK resulting in an inconsistent system to quantify the number and types of incidents across and between the four countries. The evidence suggests that NHS Scotland has not developed systems for the management of untoward clinical incidents to the same degree as England and Wales. There is little evidence that the organisation charged with the responsibility within Scotland has either taken cognisance of the systems in place elsewhere or the wider literature relating to error management – in relation to individuals or organisations. The opportunities therefore for improvements at individual organisation level are diminished.

The organisation involved within the study has adapted its policies to take account of changes in approach to the management of incidents. It has adopted some of the initiatives from other parts of the United Kingdom. At the time of the study this was a very new approach and whilst the spirit of some new principles was included it had not fully permeated throughout the organisation. This becomes more evident in the

examination of the actual clinical incidents described in Chapter 5 and the perceptions of staff explored in Chapter VI.

Chapter V

DOCUMENTATION RELATING TO INCIDENTS

BACKGROUND

There are a number of points to be considered in undertaking research using documents within the NHS. The principles adopted by historians in examination of archives and sources are relevant to this study, despite the fact that the documents under investigation are relatively modern. Nurse researchers have relied heavily on nursing documentation as a source of data in both qualitative and quantitative methods. The frustrating, consistent finding of any review of documentation is that it could be improved. The archive used in the study has been the subject of research in the past. These have however, been used mainly to establish trends of accidents and incidents within hospitals rather than as a data source examining incident management. These have commented on the quality of the record but there are few which have been used as part of a qualitative study examining the information as part of a wider process.

Macdonald and Tipton (1996) argue that when researching documentary evidence nothing can be taken for granted. This is an issue the researcher was mindful of during the data gathering in order to avoid the possibility of making assumptions about the meaning of the contents of a document rather than what has been written. Therefore, the general rule of thumb that 'if it is not recorded then it did not happen' is a principle, applied during the review of documentation. This is almost certainly the view taken during any documentary review in a legal setting. This problem in relation to documentation is also apparent in clinical nursing research. For example, Cockhill-Black et al (1999) demonstrate this in relation to research into pressure area care and documentation.

Within the context of nursing research some downplay the role played by documents in qualitative research - especially from an ethnographic perspective. Morse (1992) describes documents as providing 'additional slices' of data rather than being a single source of information and goes on to suggest that any analysis of documentation is likely

to confirm, extend or contradict findings from other data sources. Within the context of this study the documentation was the primary source of data with regard to specific incidents. Whilst the individuals involved in the incidents were approached to take part in semi-structured interviews, the purpose of the interview was to ascertain their views on the management of the incident rather than to confirm the actual details of the incident. Porter (1999) describes qualitative research as an examination of speech and conversation but adds that qualitative methods can be applied in the analysis of documents. Punch (1998) argues that the rise in “more fashionable forms of research” such as experiments, surveys, interviews etc. has resulted in a rich source of data in social research (both contemporary and historical) being neglected. Punch goes on to point out the irony in that documentary data was instrumental to the development of social science research.

Fairlie & Brown (1994) examined the reported accidents and incidents involving patients in a mental health service. Whilst the research used the incident record as a primary data source the information gleaned from the source was in the main quantitative. For example the research examined the number of reported incidents and when during the day they occurred. The research made no real recommendations over the management of the incidents but did make recommendations as to how the incident might be prevented from happening again.

FACTORS INFLUENCING THE CHANGE IN DOCUMENTATION

As described earlier in relation to the policy documents, different documentation relates to the different policy framework within which incidents are managed. At the outset of the study the policy required that each incident had an incident form completed and submitted with any supplementary information from the staff involved and any witnesses. The design and content of the pro forma had been changed considerably over a period of time. There are two main reasons for these changes:

1. **Organisational changes:** These were part of wider NHS structural changes whereby units that were directly managed through Health Boards developed into independent NHS Trusts, later merging to form new, larger NHS Trusts. Most

recently NHS Trusts have been abolished and individual units have combined to form unified Health Boards. Two of these structural changes had an impact on the documentation reviewed over the period of the research. The centralist approach taken pre and post NHS Trusts demanded that information gathered was done in a uniform manner using similar documentation whereas the freedom afforded to NHS Trusts resulted in a proliferation of different systems across different organisations within similar geographical areas.

2. Policy changes: A variety of policy changes demanded different approaches to incident management and the need to collect data relating to incidents. Organisations have been faced with a challenge of minimising the number of different documents required to meet the various demands. For example health and safety, violence and aggression, medication errors, accidents, incidents and risk management issues have all demanded some form of formal monitoring through pro forma. This has resulted in organisations attempting to pull together as many of the dataset requirements onto one pro forma. The danger of such a strategy is that information is missed completely, gathered needlessly or duplicated.

DOCUMENTS USED WITHIN THE STUDY

The main archive used during the investigation was the incident report. This was in some cases supplemented by a statement or statements from the main parties involved in the incident. The supplementary information was used to enhance the basic questions asked within the pro forma. The 1970s, 1980s and 1990s saw a number of major changes in nurse management and the role of nursing officers as well as other hospital administrators. This resulted in a gradual move away from 'administrative' roles towards more 'managerial' roles. Anecdotal evidence suggests that there are now fewer nurses in administrative positions, which has resulted in deterioration in not only the completion of but also the accuracy of the documents.

The importance of accurate completion of documentation is re-emerging within the health service as clinical risk management schemes are being more fully developed. A major factor within the Clinical Negligence and Other Risk Indemnity Scheme (CNORIS) is the accurate completion of relevant documentation and the way in which this is used to inform changes in practice to prevent a recurrence of a similar incident. This change in context has parallels with more historical archives where for example during the Colonial period in India when administration processes were more strictly regulated, the documentation (both in terms of quality and quantity) was significantly greater than in either the pre-colonial or post-colonial periods.

The incident report is one of a number of documents, which is part of health service bureaucracy, used under specific circumstances as opposed to the day-to-day elements of the patient's record. However, its completion should be regarded with the same degree of importance as other forms of documentation. The significance of accurate and well maintained nursing records is well recognised within the profession as well as a number of different external bodies. Within the profession the governing body United Kingdom Central Council (UKCC) [later becoming the Nursing and Midwifery Council (NMC)] has set standards in relation to nursing documentation and the Department of Health produced specific training programme relating to the need for accurate record keeping. From a legal perspective the nursing record is as important as the more commonly quoted medical record - which should more accurately be called patient health record. It has also been noted in a number of fatal accident inquiries that the nursing documentation is on the whole of a higher standard than the medical notes.

Scott (1990) differentiates between four different types of documentary evidence. These are closed, restricted, open-archival and open-published. Within this research study the archive falls under the classification of restricted and as such the researcher received prior permission from the Chief Executive (as the accountable officer) of the subject organisation to gain access to the relevant documentation. Access to closed and restricted information can be difficult, despite a more open approach within the health service. Hughes et al (2000) argue that the legislation, which will improve access, is likely to

present researchers with significant dilemmas. They go on to argue, "Health service researchers should regard freedom of information legislation, not simply as a resource, but a topic deserving study in its own right." Scott (1990) identifies 4 main criteria which researchers are likely to use in determining the quality of the document under investigation, namely; authenticity, credibility, representation, and meaning. A number of basic questions were presented in undertaking a formal critique of the documentary source.

- Who generates the document?
- How are the documents written?
- How are they read?
- Who reads them?
- For what purposes?
- On what occasions?
- With what outcomes?
- What is recorded?
- What is omitted?
- What assumptions are made by the generator of the document?
- What do researchers need to know in order to make sense of them?

INFORMATION REQUESTED

The consistent collection tool for incidents was the incident reporting form, designed to obtain some basic details relating to individual incidents. The form, which asked 8 simple questions

1. Who was involved in the incident?
2. When and where did the incident occur?
3. Apparent circumstances of the incident?
4. Did the person suffer injury or ill health?
5. Apparent cause of actual or potential injury / ill health?
6. Did the person receive any attention?
7. Name and address and designation of any witnesses to the incident?
8. If the person is a member of staff how long were they off work?

The resultant data sets were recorded in the form of free text, tick box or coded information. Additional information supplemented this basic dataset in the form of statements from the individual(s) involved and from any witnesses there may have been to the incident. Other documentation that was relevant to the investigation (for example the patient's drug prescription and recording sheet in a medication error) may have also been included in the documentation pack. These were not expected to be prepared in a uniform manner and there was therefore significant variability in the quality and quantity of information supplied within each incident. The nature of the incident also had an impact on the level of detail provided.

COMPLETION OF PRO FORMA

From the documentary evidence it was not the case that incident reporting forms were completed in all incidents. Of the 53 incidents investigated only 10 (19%) had a completed incident pro forma and the remaining 43 (81%) had no incident form available. The research recognised that this did not necessarily mean that there was no form completed but that it was not available as part of the documentary evidence. However in organisational terms this would suggest that the mechanisms for monitoring such incidents were disjointed and that there was not a single route for the collation and retention of this information. Given that there were some documents relating to incidents then it was possible to confirm the incident had taken place but the Trust policy of completing a standard pro forma for each incident could not be confirmed as a number were missing.

One unit of the organisation did not appear to use the relevant documentation for significant untoward clinical incidents. However, the same unit did appear to undertake a full investigation albeit using a different method than the policy demanded. This part of the organisation used a multi-disciplinary / multi-professional, critical incident technique to investigate any untoward clinical incidents. The manager involved in this area recognised that the organisation's policy was not being followed strictly but argued that the outcome of the investigation was a more detailed understanding of what happened and was conducted in a more transparent, less threatening atmosphere. The incident

reporting forms were used within this unit to deal with 'lower level' incidents, which did not require the level of investigation warranted through the critical incident technique described.

This individual application of policy within an operating department of the organisation was also evident in individual applications of policy between managers within the same directorate. Within a single directorate two different managers applied very different approaches to the management of incidents using the same policy framework. The older 'more traditional nurse manager – more like the old nursing officer' (Staff Nurse) adopted a very strict disciplinary approach to the management of medication errors. This was in stark contrast to another manager who adopted a much more reflective approach where staff involved in such incidents had an opportunity to reflect on the incident, what had caused the error and how it could be avoided in the future.

The differences between the two managers were illustrated in the record keeping. The records from the first manager related only to the initial incident form and the outcome of a disciplinary process. With the second manager there were detailed records including witness statements, the 'perpetrator's' account of the incident as well as their own reflections. This was an interesting finding in that other evidence suggested that the 'more traditional nurse manager' would have taken a more stringent and disciplined approach to ensuring that the relevant documentation was completed and maintained. This was manifestly not the case in this example. The adherence to strict bureaucratic processes is a recognisable trait of what this particular staff nurse described as the 'old nursing officer' often caricatured by an officious individual carrying a clipboard.

OTHER DOCUMENTATION

Many of the incidents contained other relevant documents such as statements from individuals involved, copies of appropriate parts of patient's records and copies of any relevant documentation. Due the significant differences in approaches of individual managers there is a wide variation in the quality and quantity of information contained within this range of documents. Many of the submissions, particularly statements made

by individual nurses, were hand written with apparently no attempt to check grammar, spelling etc and therefore it could be argued that there was no check of the accuracy of the information the statement contained. A number had been typed and then signed by the individual. This not only ensured that the document was readable it also resulted in a permanent hard and soft copy should they be required at a later date.

DOCUMENTATION RELATED TO THE INVESTIGATION PROCESS

The documentation trail in most of the incidents stopped at the point of the formal investigation meeting and started once again when the investigation was completed. For example there were no minutes of investigative meetings included within the documentation packs. Once again the researcher recognises that these may exist but were retained elsewhere. The exceptions to this were those incidents investigated using a formal review of processes involving a physical walkthrough the system. Arguably those incidents, which did not strictly follow the procedures outlined within the policy, provided fuller information about the incident, the areas for improvement and the agreed actions. Any qualified nurse should be aware of the need to ensure that documentation is completed accurately and timeously. This is a requirement of both organisational policies as well as being part of the standards expected by the governing body.

COLLATION OF INFORMATION

The organisation had pulled together a summary report of the clinical incidents over a period. These reports were taken from the incident reports and varied considerably in the amount of information, which it contained as well as any follow up actions. For example one entry was

‘Loss of vicryl 8’0 needle at the end of adjustable suture procedure. Full search – tray, floor, clothing, soles. Patient clothing and furniture.’

The information relating to this incident was lacking in various areas. For example there is no clear indication which clinical procedures had been employed, whether the needle was eventually found and what further actions could have been taken to prevent a recurrence. Whilst there is no evidence that this incident resulted in a sharps injury to

either a member of staff present at the time of the incident or to another member of staff in the clearing up process, sharps injury as a result of poor practice is one area of concern, which has been the subject of considerable attention by individual organisations, professional bodies and the press.

The information collated from the incident reporting forms then formed the basis of reports that were provided in an anonymous format to provide high-level reports on the number and nature of incidents. As the incident recording forms were not specific to clinical incidents these reports related to a wide variety of incidents including verbal and physical abuse from patients and relatives, health and safety concerns, manual handling problems and complaints. Clinical incidents tended to be extracted from this process and passed to the relevant executive director for review.

SUMMARY

The pro forma, which had been developed as part of the policy, was intended to gather some very basic details about the incident rather than being a comprehensive record of the incident. As such there is a lack of consistency relating to the information gathered as well as the method in which it was gathered. Therefore in examining the records there are varying degrees of breadth and depth of the information available, which was then used as a formal investigation. These ranged from little more than the actual incident form all the way through to a full report, describing the incident in depth as well as a full description of what should have taken place.

The way in which the documents were completed also varied considerably. This lack of consistency is something noted by investigating officers. One individual reflected their concern in a report: -

‘I have since been in discussion with X regarding the handling of this type of situation and I am advised that a group of senior staff and pharmacists are looking at the whole process.’

In the interim I feel that there is no consistent documented guidance regarding how this incident should be handled and we would welcome

some form of draft protocol. I also feel that it is crucial that we have a system to record and monitor these instances at ward and directorate level in order to analyse and identify what the issues and training needs are.’
(Charge Nurse)

This clearly reflects a concern amongst those who are expected to investigate such incidents as to the lack of due process.

The purpose of any documentary system is to obtain as much information about a situation as is required in order to complete the function of such a system. In this case it must be to ensure that data are gathered in order to assess the number and nature of untoward clinical incidents. The pro forma was designed to gather basic demographic information with more detailed information being gleaned from individuals’ statements from those involved. From the examination undertaken the following deductions may be made.

- There is wide variation in the completion of each pro forma. Not every reported incident appeared to have a pro forma available. Where these were available the details not requiring any specific narrative were completed. In many cases the information contained within the free text boxes added little to the information contained in other parts of the form.
- The additional information provided also varied widely. The variable factors included the nature of the incident, the severity of the outcome and the managerial unit in which the incident occurred.
- The use of a formalised, pre-determined pro forma tends to offer a degree of security to both the organisation and individuals reporting incidents that they have ‘ticked a box’ in ensuring that an incident has been recorded and therefore reported, rather than using this as a tool for ensuring that incidents are examined in detail.
- If the adage ‘if it is not recorded it did not happen’ were to be applied to the individual pro forma then the information obtained provided little insight into the incident itself, its causes or its outcomes.

- There remains a tendency within some reports to record what may have happened rather than what actually was witnessed by the individual reporting the incident.
- Formal investigations, which adopted a descriptive style involving a 'walkthrough' the incident, provided the most detailed account of the error, its antecedents, roles played by individuals, weak points throughout the sequences of events and as a result offered areas requiring definitive action to prevent recurrence. This format was only undertaken in a small number of occasions.
- The newly adopted "root cause analysis process" adopts a similar approach. However it has a prescriptive approach, which potentially loses some of the apparent freedom offered by the scheme described above.

The issues relating to the accurate completion and maintenance of documentation as part of formal records within this study reflect those demonstrated within the literature. There were a number of examples where the standard of record keeping in relation to the process of managing the process rather than the incident itself was very poor. These included complete documents missing, misfiled documents (e.g. documents relating to different incidents being filed together), and recording errors relating to the outcome of investigations.

Chapter VI

CLINICAL INCIDENTS

THE CLINICAL INCIDENTS

The subject organisation is divided into a number of clinical and non-clinical directorates. The incidents involving qualified nurses fall into three main directorates. The aim of the research was not to examine the number of incidents reported and therefore there is no attempt to quantify the incidents. As the research is concerned with only those incidents involving qualified nurses and there are no studies specifically looking at the number of incidents in relation to nursing contacts, no comment is made as to whether the incidence and types of errors involving qualified nurses is similar to other studies. However, it is acknowledged at the outset that the number of incidents included within the research does not constitute all untoward incidents involving qualified nurses. The key reasons for this are:-

- Not all incidents are reported.
- Not all incidents are recognised as such.
- Some incidents may have been managed outwith the recognised reporting system.
- There may be gaps in the reporting mechanism.
- Systems are not geared towards gathering incidents specific to individual disciplines.

Therefore the incidents included within the study are those involving qualified nurses, have been managed through the recognised policy and have the relevant documents available for scrutiny. A summary of the incidents and an analysis of the category into which they fall are detailed within appendix 3

DIRECTORATE I

A total of 15 incidents were examined within this directorate. Whilst the documents relating to all 15 incidents were reviewed, only the staff involved in 6 of these were contacted in order to seek consent to take part in the semi-structured interviews. It is not

appropriate to explain fully the rationale for excluding these members of staff as to do so could inadvertently reveal the identity of the subject organisation. One of the conditions of access was a guarantee of anonymity for the organisation and the individuals who agreed to take part. Accordingly, they have been excluded from the interviews but included in the review of incidents.

Incident 1 (Drug Error)

In this incident a patient received the wrong dose of morphine sulphate. A registered nurse (RGN), 1st level nurses and an enrolled nurse (SEN), 2nd level nurse were involved in the procedure. They both reported that they felt they had followed the recognised procedure to ensure that the drug was safely dispensed and administered to the correct patient according to the prescription. However, during the investigation they accepted that they had not followed the correct checking procedures resulting in the patient receiving the incorrect dose. Within the classification outlined in chapter II this would be regarded as a skill based error. Both nurses submitted written descriptions of the processes they employed and how the error was brought to their attention. The documentation associated with this incident was incomplete in that an incident form was not available. Interestingly the incident form included within the documentation, was for a completely different incident altogether.

The outcome was that both nurses involved in the incident were the subjects of a formal investigation as part of a disciplinary process. The same manager who undertook the investigation then instituted the disciplinary processes. This does not follow the procedures as outlined within the organisational policy for clinical incidents. The policy directs that a manager should conduct the investigation and if disciplinary procedures were then thought to be necessary the investigation officers present their finding to a different and previously uninvolved manager who would then decide whether disciplinary action was necessary and to what level. The practice of conducting the investigation and disciplinary process concurrently by the same manager was accepted as contravening the organisation's policy and procedure and had become the accepted norm throughout the organisation. The outcome in this case was that both nurses were

disciplined to the level of an oral warning, the first level of a hierarchical disciplinary action, which has dismissal as its ultimate action.

In the letter to staff confirming the outcome of the investigation and disciplinary meeting, the manager confirms that the nurses' representative commented that, in mitigation, the workload and staffing within the ward may have contributed to the incident and that this should be taken into account. This was duly acknowledged by the manager who suggests that the times for ward rounds should be reviewed with a view to 'flattening' the workload throughout the day by reducing peaks in activity. There is also some attempt to ensure that staff are supervised and educated further to prevent recurrence.

"As confirmed at the meeting, I note you and your representative's comments regarding the workload / staffing in Ward (number) on that day and I shall discuss with the ward team to ascertain whether drug rounds etc can be changed to a different time of the day. This would alleviate the workload issues there appear to be in the mornings. In addition and as discussed, I think it would be useful for you to have a clinical supervisor, this will provide a means of support for yourself. I will discuss this further with (name), Charge Nurse, Ward (number) and yourself. I will also arrange for a training session to take place with a representative from the Pharmacy Department with the objective of you becoming fully conversant with the procedure for administering controlled drugs."

There is no evidence within the documentation that system changes and support & training were instituted or whether these had been instrumental in preventing similar incidents.

The nurses involved, as part of the organisational policy had the opportunity to appeal against the decision. There is no evidence that they chose to appeal this decision. This would tend to suggest that they accepted that they had made an error and that the appropriate action to be taken against them was disciplinary action alongside additional supervision and training, as well as a commitment to review the systems that may have contributed to the error. Interestingly the organisation had in place a system following up actions for complaints made against the Trust but had no system for following up actions

agreed as part of clinical incidents. Indeed the follow up actions for any complaint made was a standard report to the Trust Board, the most senior managerial committee.

Incident 2

In this incident, two patients were both due to receive blood transfusions and were in beds next to each other in a four-bedded room. Two members of the nursing team checked each of the two units of blood, as per the recognised procedure. One member of staff, the more senior, was called away to collect a patient from theatre. The more senior member of staff outlines in her statement that she instructed the more junior member of staff not to commence the transfusions immediately, but to wait upon her return. The more senior member of staff then left the ward to collect the patient from theatre. The more junior member of staff, having apparently not heard the instruction not to commence the transfusion, waited until the units of blood had reached an appropriate temperature and then commenced both transfusions, five minutes apart. On returning to the ward, the more senior member of staff undertook routine vital sign recording and discovered that each patient had the wrong blood. The transfusions were stopped immediately and appropriate medical assistance sought. The blood transfusion service was contacted who advised that as both sets of blood were the same group and there were no antibodies, it was unlikely that there would be any adverse effects on the patients. Incident forms were completed for both patients. Within the classification outlined within chapter II this would be regarded as a violation.

An investigation into the incident was conducted as part of the disciplinary process and both members had submitted their statements in relation to the incident. Their respective trade union/professional organisation representatives accompanied both members of staff to the investigative hearing. These were from two separate organisations.

The more junior staff nurse recognised that the correct procedure for commencing a blood transfusion was to have both nurses check the relevant details and be present when the transfusion was commenced and, as such, recognised that she had deviated from the

accepted procedure on this occasion. In mitigation, the staff organisation's representative made comment on the workload and staffing levels in the ward at the time of the incident

"As confirmed at the meeting, I note you and your representative's comments regarding the workload/staffing levels of the ward and I shall discuss this with (Name), Ward Manager, as soon as possible. In addition, I will arrange for a training session to take place for all staff in the unit on the procedure for giving blood to patients".

However, the more senior member of staff did not offer areas of mitigation and these were not acknowledged in the same way in the written communication

"I will arrange for a training session to take place for all staff in the Day Bed Unit on the procedure for giving blood to patients via the safe transfusion guidelines. The same education and informative session will soon be obligatory for all throughout the Trust".

It is unclear from the documentation why two different approaches appear to have been taken to two different members of staff, both involved in the same incident. The only variable factor was representation from different staff organisations. It is also interesting to note that in the letters to the members of staff indicating the outcome of the investigation/disciplinary hearing, one member of staff receives a first written warning (i.e. the more senior member) and the more junior member receives a verbal warning. The investigating manager then corrects this apparent anomaly by indicating to the more senior member of staff that the disciplinary level should have been verbal warning. The manager then goes on to state

"The body of the letter states the correct disciplinary action, however, the more junior member of staff receives a letter indicating a verbal warning in the main heading of the letter, but indicates a first written warning in the body of the text"... "After careful consideration of the evidence, and in view of the nature of the incident, I consider you should be given a first written warning. This warning will be placed on your record for six months and will be removed after this time. If there is a further related offence, this may lead to further discipline. This warning has been given for unacceptable clinical performance in relation to the giving of blood to patients".

In the case of the more senior member of staff, the corrected title of the disciplinary letter is verbal warning, and this is confirmed in the body of the text

“After careful consideration of the evidence, and in view of the nature of the incident, I consider you should be given a verbal warning. The warning will be placed on your record for three months and will be removed after this time. If there is a further related offence, this may lead to further discipline. This warning has been given for unacceptable clinical performance in relation to the giving of blood to patients”.

There appears to be no justification within the documentation as to why each Nurse has been given a different level of disciplinary action. Both letters, however, make reference to additional training and one of the letters, in mitigation, makes reference to workload and staffing levels within the ward. There is no evidence within the documentation that further training was initiated, other than a single bullet point in a memo updating action after the incident which states

“Charge Nurse (Name) is doing the distance learning pack for blood transfusion trainers and training is being organised for all (ward name) staff in safe blood transfusion”.

There is no specific training noted for the two members of staff involved in the incident. There is a more extensive discussion around the workload and staffing issues within the ward, in particular:

1. staffing levels within the ward
2. skill-mix issues within the ward
3. Staff cover at peaks and troughs in workload
4. waiting list patients sent to ward without adequate warning

In this incident, two qualified nurses were disciplined to different levels for their involvement in the same incident resulting in two patients receiving incorrect blood

transfusions. There are a number of errors within the official documentation in relation to the outcome of the investigation/disciplinary hearing. There is no evidence within the documentation that targeted training programmes for the individuals had been developed or initiated. A blanket approach to further education in relation to this procedure was noted, but no confirmation of follow-up action having been completed.

Incident 3

The documentation available for this particular clinical incident does not conform to the procedure set out within the policy framework. There was no incident report form, nor any statements from those members involved at the incident. In this incident, two patients were being managed through an endoscopy area:

- Patient 1, male patient, had a colonoscopy undertaken
- Patient 2, female patient, had an upper endoscopy and a gastric biopsy having been taken

A specimen from the gastric biopsy, from the female patient, was sent to the laboratory, the results of which confirmed the presence of a tumour. The patient had an oesophagectomy two months later, during which times specimens were sent to the laboratory and the results established that there was no tumour present. Further analysis from the laboratory, i.e. DNA analysis, confirmed that the specimen belonged to a male patient, not to a female patient. A report on the male patient concluded that biopsies were not received by the Department of Pathology. It was therefore concluded that an error in labelling of the biopsy specimen within the clinical area prior to sending to the laboratory had resulted in misdiagnosis in the female patient, with resultant major surgery to remove the oesophagus. Within the classification outlined within chapter II this would be regarded as a rule based error.

The investigation into this incident took the form of a formal review involving managerial staff, clinical staff from the area and staff organisation representatives walking through the process involved in a patient's journey through this particular

clinical area. At each stage the review team sought clarification on the normal processes, procedures and practices in order to establish how and where this error could have occurred as well as identifying what changes were required within the system in order to prevent recurrence. The result was an extensive report into the process with a number of recommendations. In conducting such a review of the patient journey, the review team made 37 recommendations as to how the process could be improved in order to prevent recurrence. The report also demonstrated that the activity within this area had almost doubled within a five-year period and, as such, was now dealing with a significantly higher throughput of patients than the unit had originally been designed to deal with. By undertaking such a process the review team was able to identify and pinpoint very accurately the cause of the incident

“It was evident to the review team that the system to ensure accuracy of biopsy is dependent upon the correct labelling of the universal container at the time the biopsy is obtained and that this must then be placed with the pathology form for completion. In highlighting the stages of the patient journey, it was evident that the attention given to the checking of the patient with the case-notes was haphazard, staff verbally name the patient at each stage, but did not consistently check the case-note unit number with the patient and their name band. In addition, the number of loose sheets of paper attached to the case-notes was not consistently checked for accuracy prior to use. The consequence of this omission of checking presents a significant risk factor for the patient at each stage of their journey”.

There is no evidence within the documentation that individual members of staff involved in this incident were subjected to individual investigation and/or disciplinary action. It appears that a process whereby a review of the current systems was seen as a more appropriate way of investigating this type of clinical incident. Unfortunately, there is no documentary evidence to suggest that the recommendations made within the report have been implemented and therefore whether they have been effective in preventing a recurrence of a similar incident.

In conclusion, this clinical incident arose from the mislabelling of a sample, which resulted in a patient undergoing unnecessary surgery. The investigation into the cause of

the incident did not follow the organisation's procedures contained within the policy for dealing with such incidents, yet appears to have achieved its overall aims of identifying the cause of the problem, some of the reasons why the error had occurred and was able to make recommendations as to how the whole system within which the patient was managed could be improved in order to prevent a recurrence.

Incident 4

The documentation relating to this incident was very similar to that in incident number 3. The same manager oversaw both these incidents. In this incident a senior staff nurse observed a junior staff nurse complete a procedure as part of a pre-assessment process for patients due to undergo cataract surgery. This involved taking some physiological measurements of the eye to identify the correct lens required for implantation. During the process the results of the examination are printed onto paper and this is then used to inform the surgeon of the lens required. The senior staff nurse noted that the junior staff nurse activated the printer from the printer itself rather than from the hand piece of the keratometer. The outcome of this was that by activating the printer itself the results of the previous patient was printed. Accordingly, it was likely that for a number of patients the wrong lens was identified for surgery. The issue was further complicated in that some patients were having their surgery undertaken in a separate institution. It was also recognised that another new member of staff was also perpetrating the error. Both nurses had been undertaking these assessments for approximately 3 months. Within the classification outlined within chapter II this would be regarded as a rule based error.

The immediate priority in the incident was to ensure that all potentially affected patients were reviewed to ensure that any problems could be rectified as quickly as possible. This would have been detected at one of the post-operative checks conducted 3 weeks after surgery. The majority of the patients (85%) had had their post-operative check within a short time of the incident and had been found to have no overt anomalies. A number of patients (20) were noted to have had the assessment undertaken by the nurse in question but had not at that time had their surgery. The assessment would therefore be repeated on

the morning of surgery ensuring that any alterations to the lens type could be made in advance of the surgery.

This incident demonstrated a number of weaknesses that could lead to such an error within the patient pathway. Through the investigation these were noted and an action plan was formulated to address each of the weaknesses. The plan identified each of the problem areas, what action needed to be taken, what progress had been made, who had the lead responsibility and the date the actions were completed. This detail was included in a final report submitted by the manager involved to the medical director. The follow up action was directed through the medical director as some of the patients were being treated in other centres and the medical director ensured these centres were aware of the problem and advised appropriate actions. The consultants and the senior nurses within this clinical setting were jointly involved in pulling together a revised operational policy to prevent a recurrence. It is clear from the documentation that the actions taken involved not only those within the affected department but also wider areas such as clinical physics.

There is documentary evidence that the nurse involved in this incident was requested to attend an investigative meeting but there is no evidence that this took place and if it did what it concluded. The nurse involved in the incident and the manager responsible for the management of the incident had both subsequently left the organisation and therefore were not part of the cohort of interviewees. Accordingly, it was not possible to have these issues checked with them personally. Once again an approach, which did not follow the organisation's policy and procedure, was able to obtain a more detailed account of an incident and facilitated its effective management.

Incident No. 5

In this incident, a patient was being looked after within a high-dependency area, post-operatively, and had an epidural infusion in situ. The epidural infusion was due to be removed and therefore the pump attached to the epidural, and required to deliver the medication, was switched off at the time of the incident. At this time, the patient was up

sitting at the side of the bed, the nurse providing the care assisted the lady to change her nightwear and then helped her back into bed. In order to remove her nightwear, the patient-controlled analgesia pump was disconnected at the peripheral venous cannula and the line fed through the clothing. The nurse believed she reconnected the pump connected to the epidural line correctly.

The anaesthetist responsible for the care of the patient visited and noted that the epidural infusion line was attached to the peripheral venous cannula and the patient controlled analgesia infusion line was not attached to anything. The nurse caring for the patient immediately rectified the error. The epidural pump was switched off at this time and therefore the patient did not receive anything intravenously as a result of the epidural line having been connected to the peripheral cannula. Accordingly, the mistake was identified prior to any of the pumps being switched on and therefore was regarded as a “near miss”. The following day, a meeting was established to review the “near miss”. Taking part was a consultant anaesthetist, a senior manager, nurse manager and staff side representative. During the meeting, five main points were identified in relation to the near miss. These were noted in the documentation as follows:

1. Best practice in relation to changing nightwear was breached which allowed for the incident to manifest itself.
2. Epidural line had become disconnected at the filter unknown to the nurse who had then connected this line peripherally.
3. Peripheral infusion line and epidural line were not labelled.
4. No difference in giving lines to alert the nurse to potential error.
5. Current epidurals infused via (name) infusion pump which is routinely used for intravenous infusions only

During the meeting to review the incident, it was noted by those present that there had been a number of incidents and “near misses” with regard to epidural infusions which had been reported in the lay and professional press over a period of time, including on the morning of the meeting. The meeting concluded by making six main recommendations in order to prevent a recurrence of a similar incident regarding epidurals. These recommendations were:

1. All patients who required an epidural infusion should be cared for within a high-dependency unit.
2. Epidural lines should be clearly labelled at the time of insertion. This would be the responsibility of the anaesthetist inserting the line.
3. At the time of handover in theatre recover, the line will be visualised by the receiving nurse
4. Epidural pumps to be purchased which differ from the current PCA infusion devices to minimise the risk of confusion.
5. Separate education should be set up with regard to the new infusion devices.
6. Clinical incidents should be discussed in a variety of meetings and all staff made aware of the changes in practice.

The documentation relating to this incident took the form of a report outlining the issues in areas of the incident and a formal minute of the meeting to review the incident and the recommendations made. Under the policy guidelines, which were in place at the time of this incident, (regarded as a near miss) there was no requirement to record formally the incident itself, nor actions taken. It is clear that the relevant parties involved in the incident and those required to initiate such actions in order to prevent a recurrence of the same, were involved throughout.

This incident demonstrates an issue with regard to how lessons learned from similar clinical incidents throughout other parts of the health system are identified and disseminated. In a similar but fatal parallel example, there have been reported 10 incidents of patients who have died as a result of incorrect intra-thecal injections. In relation to this particular incident members of the review team were able to cite similar difficulties elsewhere yet there was no formal mechanism to identify and quantify the risk, undertake a formal risk assessment, agreeing potential solutions and implementing change programmes to prevent recurrence.

The documentation does not at any stage identify the individual nurse involved in the near miss and therefore there is no record of any formal discussions with the individual or corrective action to be taken. This would clearly be part of the agreed actions to be implemented with the wider group of staff. This incident illustrates clearly how an incident or potential incident can be investigated fully without the need for an in-depth

investigation concentrating on the role an individual played. All the relevant information was gathered to allow a relevant multi-disciplinary group to review the circumstances and provide clear guidance to prevent recurrence. There are clear parallels with systems developed and implemented within the aviation industry where both actual incidents and near-misses are reported anonymously and have proven to be a useful tool in the reduction of incidents overall as well as improving individuals' willingness to come forward when an untoward event has occurred.

Incident No. 6

This incident took the form of a complaint made by a member of staff against a different member of staff with regard to his attitude during a cardiac arrest.

The member of staff making the complaint reported three main areas:

1. On his arrival he immediately complained that the ambubag in use was not effective and demanded a replacement. This was duly done. His attitude was commented upon when he left by me.
2. When resuscitation had ended, he confronted staff nurse (name) at the nurses' station, complaining about dead? Ambubag and went on to infer that no checks were made on the equipment by ward (name) nursing staff. This inference was made in my presence, he continued by pointing his finger into staff nurse (name) face. I asked him to refrain from doing this, and if he had concerns to take them to his superior. I then returned to the bay.
3. I came back to the nurses' station to discover that he was continuing his verbal assault on staff nurse (name) and informed him that the conversation was now at an end and advised staff nurse (name) to discontinue conversation with him. He left by informing us that he would be reporting the matter to a consultant anaesthetist. I told him I would be informing his superior that I was unhappy with his conduct and this I now do".

The member of staff was then contacted by his line manager and asked to provide a written explanation, dealing with the points that had been raised in the formal complaint. In doing so, he recognised, and indeed accepted, that his conduct was not as it should, or could, have been and offered his apologies. However, he also commented on a number of areas of concern with regard to the equipment required for cardiac arrest and, as such,

found himself in an emergency clinical situation that was very tense and very stressful. He pointed out that a number of pieces of equipment were defective, that it appeared that at least daily checks on these pieces of equipment had clearly not been undertaken or such defects would have been detected, and that the other nurses involved in the cardiac arrest had taken longer than would normally have been expected in order to find replacement equipment.

This incident was not reported formally through the clinical incident procedure as each cardiac arrest was formally recorded through a different system, and the resuscitation-training officer took up any issues with regard to the management of cardiac arrest. These documents were not available for the study. It is noted however in the report that the manager involved in investigating the initial complaint had discussed the situation with the resuscitation training officer and additional training was agreed for those areas involved in the incident. The situation also demonstrates how the charged environment in which cardiac arrests are conducted can have an impact on the way individuals react in particular where there is a poor outcome. It also illustrates the facts that acts of omission or commission, which are antecedents to the actual incidents impact on the incident although may play little or no role in the incident. For example the equipment was apparently not examined regularly. Such checks would have brought to light any problems with the equipment and this could potentially have avoided the situation arising.

Incident No. 7

This incident took place within an operating theatre toward the end of an ophthalmic procedure. The procedure involved the use of a diamond knife. Towards the end of the procedure, the scrub nurse who had assumed that the requirement for the said knife had come to an end, passed the knife over to the floor nurse, thus rendering it no longer sterile. The surgeon then encountered a difficulty and required the knife back. There were no spare knives available and therefore the only one that could be used was that which had been handed off to the floor nurse. In order to sterilise the knife, the floor nurse was instructed by the scrub nurse to place this within a bench-top steriliser within

theatre, which had a short cycle. However, during the cycle required for sterilisation, a different member of staff came into the room and opened the sterilising equipment, which resulted in the cycle not being completed, and therefore no guarantee of sterility. The nursing staff did not know this at the time. The knife was handed back to the surgeon and the procedure was completed. When the interruption to the sterilising cycle had been identified, the surgeon was immediately informed who then informed the patient in order that he could report any problems with a subsequent eye infection. The patient was followed-up some time later with no difficulties. Within the classification outlined within chapter II this would be regarded as a rule based error.

The appropriate documentation was completed for this incident and the staff within theatre were reminded to ensure that bench-top sterilisers were being used properly. This incident once again identifies the way antecedents of actual incidents have an impact on the incident itself. In this case the 'error' was the use of an unsterile piece of equipment believed to be sterile by a number of individuals who played a role in the scenario. The reaction to this incident is also helpful in demonstrating the 'reminder' culture, which has developed as a result of a greater understanding of risk.

Incident No. 8

In this incident, it was noted by a member of staff that the equipment used for the sterilisation of surgical instruments within a theatre had aborted its process mid-cycle. This resulted in there being no guaranteed that the instruments were sterilised. However, this was not recognised by staff and the equipment had been removed and used on three different patients before the incident could be reported. All of the instrumentation at the time was part of surgical equipment required for intraocular surgery under local anaesthetic. Some of the pieces of equipment were required for handling other pieces of equipment and therefore did not come in direct contact with the patient. Others, however, were used as part of the invasive procedure.

When this was pointed out the surgeon involved ensured that patients received appropriate antibiotic cover to minimise the risk of any resultant infection. There were

no reports of any complications experienced by patients as a result. Within the classification identified within chapter II this would be regarded as a rule based error.

The appropriate documentation was completed and an investigation undertaken. This included theatre staff involved in the incident as well as the infection control team and the health and safety advisor. During the investigation, it was noted that normal practice was for such instrumentation to be sterilised during the night in order to maximise the instruments availability during normal working hours. Under normal circumstances the steriliser provided a print-out which identified the times that the sterilisation was conducted and this was used as confirmation that the cycle had been completed and thus an assurance that the instrumentation was, in fact, sterile. On this occasion, not only did the machine identify that the cycle had been aborted, but there was no print-out and this should have alerted the member of staff moving the instruments that the cycle had not been completed, the equipment could not be regarded as sterile and therefore should not be used. A number of actions were taken to prevent recurrence of this including:

- targeted additional training for the individual member of staff
- general training for all relevant staff
- additional information for key staff using the sterilisation method
- a revision of the protocol for the release of instrumentation following sterilisation

This incident is similar in many ways to the previous incident in that the final actors involved in the error were not directly involved in the procedures which ultimately resulted in the error being committed. It is also interesting to note that both these incidents occurred in the same clinical facility yet the actions taken to prevent a recurrence are more stringent and more focussed in this incident than in the previous incident. There appear to be no obvious reasons why this may be the case, other than the individuals to whom the incidents were reported were different in both cases. However, the individual with responsibility for the overall management of the area remained constant.

Incident No. 9

The drug error in this incident was brought to the attention of an acute area following a complaint by a general practitioner, who identified that one of his patients had been an in-patient in the acute area and, during her two week stay, did not receive a key part of her therapy, this was a cholesterol-lowering treatment for patients who cannot tolerate a more routine cholesterol-lowering treatment because of an abnormal physiological recording. The patient had been in the unit for almost two weeks and, having been discharged back into the care of the GP, he discovered that her cholesterol level was raised. On investigation, it was noted that the patient had been prescribed a drug on her day of admission and for the next 13 days six qualified members of staff recorded that the drug had not been given, although there was no explanation given on the drug recording sheet, nor was there apparently any action taken in order to rectify the situation. On the 13th day, a different qualified member of staff identified that the drug was not given because it was not in stock and took the appropriate action to order the drug. The following day, it was noted that two members of staff were involved and neither recorded that the drug was not given, nor provided any comment. Of the seven qualified nurses involved with this one patient, only one followed the correct procedure; recording that a drug was not available, the reason why it was not available and took the appropriate action in order to obtain the said drug. The incident, having been presented as a formal complaint from a general practitioner, was then followed-up by the managerial staff. In mitigation, the charge nurse from the ward outlined a number of issues in relation to changes within the system which may have contributed to this incident. The main one being that the unit was accustomed to receiving regular visits from clinical pharmacists but these had recently stopped.

‘There are also several associated pharmacy issues. The ward, until earlier this year, had a pharmacist visit daily, who would check the kardex, order outstanding drugs and offer advice. I was informed by memo that this would be reduced to twice weekly but there were no days specified for the visits. I discussed this with (name), who said she would visit Monday and Friday. Although expressing my reservations, I agreed to trial this. However, only rarely did we receive twice-weekly visits, more usually, only once. In response to staff dissatisfaction within the unit with this service, I spoke to (name) on (date) and asked her to increase her visits to

the unit as the ward team felt that we had little, or no, pharmacy service. The unit was very busy at the time and the reduction in pharmacy service provision was noticeable. Further deterioration, not only with pharmacy, but also with the top-up service, was noted and I approached (name) to say how dissatisfied I was and could he offer me any help in dealing with the situation. Normal pharmacy visits would usually have picked up the fact that the drug had not been in stock.'

It was also noted that the one staff nurse who had followed the correct procedure and requested the drug from pharmacy does not appear to have had a response from pharmacy and on the discharge prescription, two days after, it was noted that they do not stock the dose of the drug required. Within the classification outlined within chapter II this would be regarded as a rule based error.

This incident is of particular interest in that it involved a total of seven qualified nurses, six of whom perpetuated the original error in not ensuring that the appropriate drug was obtained from the pharmacy department within an acceptable timeframe. The explanation presented by the most senior nurse at the time was that the area had previously enjoyed the services of a clinical pharmacist and the removal of the service was the main reason for this error occurring in that such an individual would have picked up the discrepancy and ensured that it was rectified. Therefore, it was argued, the change in the system contributed to the error. There appears to be no acceptance by the charge nurse that the change in the system was known by all the ward staff and therefore they were aware that the pharmacist would not be in a position to detect this problem and accordingly the nursing staff were responsible for ensuring that the relevant drugs were sought for the patients. It is clear that the nurse quoted above is seeking to attribute the cause of the problem to some factor other than a defect in the way nurses functioned within the ward.

Incident No. 10

In this incident, a staff nurse noted that a patient had not been given his anticonvulsant medication for the previous three days and identified and reported this as a drug error. It was noted that it had been reported on the kardex that on the three evenings where the drug had apparently been omitted the same member of staff had been on duty, and that

other drugs prescribed for the time had been given, but that the anticonvulsant medication had not been included. A senior nurse to whom the staff nurse pointed out this error, agreed to take this up with the individual member of staff. This was duly done, however, the situation was somewhat sensitive given that both nurses were of the same grade. Having sought an explanation, the charge nurse who had omitted to give the drug, reported that she distinctly remembered giving the drug, but had clearly not recorded the fact, therefore regarded this an omission of recording rather than an omission of administering medication. Within the classification outlined within chapter II this would be regarded as a lapse and a skill based error. The charge nurse who brought this to her attention then notes in her statement

‘At the time I accepted that I had brought the problem to her attention, and being her peer, felt I could do no more in terms of follow-through. I now accept, however, that I should have documented this as a drug error and brought it to the attention of my nurse manager.’

It is unclear in the documentation how the nurse manager was informed of this, but having had the incident brought to their attention, sought clarification from the charge nurse who had omitted to record the drug. As part of her explanation, the charge nurse outlined the following in mitigation:

“We were particularly busy that week with 8 patients, 2 of whom were constant-cares. In addition, we had staffing difficulties, a busy theatre schedule and the Thursday was particularly bad as we had unexpected further sickness plus a staff nurse having to go home due to a family crisis. This meant that, in addition to the ward workload, I had to nurse one of the constant-care patients, plus deal with the clinic patients. In the 3 days I worked, I had one breakfast break, 2 lunch breaks and no supper breaks as the ward demands just couldn’t provide for this. I have no recollection as to how or why I missed documenting the drug on the three nights, and can only assume that I must have been disturbed on the first evening and omitted the item. On the second and third evenings, as I was constantly being interrupted by call-bells, the telephone, and staff and patient queries, I have copied the letters from the first evenings box, not a practice I normally pursue, but as I was under pressure this is the only (poor) excuse I can offer”.

There is no further information within the documentation as to the follow-up action taken. This incident illustrates a number of issues worthy of further exploration. The first being the perceived difficulty of the first charge nurse to whom the incident was reported, in having to report a drug error to a peer and initially assuming that this could not be followed through by herself. The second issue worthy of further exploration is the mitigation offered by the second charge nurse who omitted the drug.

In this clinical area there were two charge nurses and in this particular instance one charge nurse was involved in the error and the error was reported to the second who did not feel that she had a role in dealing with the issue. That being the case it is unclear as to why she did not bring this to the attention of the person who did have the responsibility to investigate the matter. There appears to be no suggestion in the documentation that one charge nurse was attempting to cover up for another although this is a potential conclusion that could be drawn by a disinterested observer. The areas of mitigation presented by the charge nurse relate to the relationship between the workload experienced and the number of staff available i.e. that the former outweighed the latter. The charge nurse does acknowledge that this is a 'poor excuse', however it must be noted that these factors may have contributed to the overall environment in which this error occurred. The question that should be asked is whether, if the workload and staff available were in balance, was it as likely that the error would have occurred? Given that other drugs were administered and recorded accurately by the charge nurse and indeed other qualified nurses during the period the errors occurred, it is reasonable to assume that they were as likely to occur and that other factors may have been responsible for the error. It is also notable that the same charge nurse was involved in incidents number ten and eleven. On both the charge nurse offers explanations whereby she has attempted to attribute the cause of the errors to issues relating to the organisation rather than to individuals, including herself. This is well-recognised attribution behaviour and has been noted throughout the literature.

Incident No. 11

In this incident two qualified nurses started the process of checking a controlled drug in order to change a patient's analgesia being delivered via a syringe pump. During the process, the emergency alarm sounded in the ward and both nurses went to investigate and assist. It was then discovered that a patient who had observed another patient trying to climb out of bed had activated the emergency alarm. The two qualified nurses involved attempted to help the patient back into bed as he had been doubly incontinent, they both helped to clean and settle the patient. One of the qualified nurses was then required to assist with a patient who had just returned from theatre. The same nurse was then instructed to go for her break. It was at this point she remembered that she had placed the syringe containing the controlled drug in her pocket at the time the emergency alarm went off. Having then been distracted by a number of other things within the ward, the process of checking and replacing the syringe had not been completed. On discovering the syringe in her pocket, she handed this to the second qualified nurse who then completed the process on her own and re-started the patient's analgesia syringe. The formal recording process was not completed (i.e. the controlled-drug register was not completed to record the removal of the syringe from storage and attachment to the syringe driver). It was also noted by one of the nurses that the patient was changing his own syringe as part of a patient education exercise in preparation for discharge and the long-term use of this medical device by the patient.

The following day, the nursing staff on duty took delivery of a pre-prepared syringe with the patient's medication and undertook the process of recording its delivery and storage. In doing so, they discovered that it was recorded in the controlled-drug that there should be a syringe in storage, but on checking, this was not the case. The end result was a discrepancy contained within the controlled-drug register. The nursing staff who discovered the discrepancy then took steps to establish whether or not the patient had actually had their medication changed. This was established and therefore it was clear that the discrepancy was a recording discrepancy rather than the patient's failure to receive the appropriate medication. The correct steps were then taken to report the discrepancy and amend the record to reflect the situation accurately.

The two members of staff who had been involved in the initial process were then asked to provide statements for the management team in order to assess where the error lay. Within the classification outlined within chapter II this would be regarded as a skill based error and a lapse.

Both members of staff provided statements which reflected the explanations which had been given. In the statements they both make reference to the workload within the ward and whilst they do not explicitly conclude that the heavy workload was the cause of the error there is an implicit link between the error and the workload.

‘Staff Nurse (name) and myself helped the patient back into bed, however the patient was doubly incontinent. We washed the patient and changed his clothes. On completing this task Staff Nurse (name) immediately attended to a patient who had arrived back from theatre whilst I attended to other patients. The ward was extremely busy.’

‘Unfortunately, due to pressure of work, I omitted to sign the controlled drug book for the aforementioned syringe driver or record the same in the patients kardex.’

The two members of staff involved in this incident were qualified nurses, one of whom was a permanent member of staff within the ward and another who was a bank member of staff. As outlined earlier, both were asked to provide formal statements as to the events of the evening in question and the appropriate managers assessed these. The permanent member of staff was felt to require additional training in the area of the management of controlled drugs and, as such, a request to the senior nurse for the ward to assess the individual in

‘Administration and control of opiate drugs, understanding of drug administration policy and procedure for all medications, able to demonstrate on two separate occasions the drug administration procedure as per hospital policy.’

The senior nurse from the ward reports two months later that all of these objectives had been achieved and noted:

‘I found (name) to be competent in drug administration. (Name) appears to have lost some of her confidence in this area, but I hope she will quickly regain it. I will attempt to give her any further support.’

For the second member of staff who was a member of bank nursing staff, it was noted that no further action was necessary as she was dismissed from the Trust for another incident elsewhere and not related to this incident under investigation. This incident would be regarded as a classic example of a lapse and clearly illustrates an omission (failure to record the syringe in the controlled-drug book) by the two nurses as a result of a distraction (doubly incontinent patient trying to get out of bed). It is noted that there is no formal disciplinary action taken against the staff involved but a period of supervised practice was the more appropriate action. However it could be argued that this was ‘excessive’ given the circumstances and the impact reported by the ward manager would appear to substantiate this view in that the confidence of the member of staff had been adversely affected as a result of the lapse and the subsequent actions. Arguably such a loss of confidence in one’s clinical practice could in itself be an antecedent of a further error.

Incident No. 12

This drug error happened as a result of a poorly written drug Kardex.

“On the night of (date) into (date) on Ward (name), a patient in the ward called (patient name) had MST 50mg given at 0030 due to a misinterpretation of a poorly written drug Kardex. The drug was written in the column after 2200, appearing to be 0000. The problem was noticed immediately and the house officer on call was alerted at 0035 and (patient name) was given the adequate dosage of the antidote Narcan at 0045. (Patient Name) was immediately commenced on ½ hourly recording of vital signs and attached to continuous oxygen saturation monitoring. (Patient name) was aware of the situation throughout and did not appear to suffer any undue problems during the course of the night. The matter was reported.”

The second qualified nurse involved reflects this account offered by her colleague. The incident, having been brought to the attention of the relevant manager, the manager then requested that the ward charge nurse facilitate a meeting with the two staff to set objectives relating to the incident and requesting that the charge nurse provide “correspondence relating to their safety to practice in terms of medications administration”. Within the documentation available, there is no evidence of any intervention or assessment having been undertaken, nor that the manager received any assurances with regard to these two members of staff’s ability to administer medications safely. Within the classification outlined within chapter II this would be regarded as a rule based error.

This incident illustrates a particular issue with regard to nurses apparently committing an error as a result of a poorly written prescription chart. This is an area which causes considerable discussion as to where the problem and cause of the error actually lies, i.e. does the fault lie with the medical practitioner whose prescription was unclear, or does the cause lie with the qualified nurses who made assumptions with regard to the lack of clarity around the prescription. Within the documentation there is no copy of the patients drug kardex, therefore it is difficult to assess how unclear the prescription was or, indeed, whether the drug had been administered on other occasions. The correct procedure for an unclear prescription is to have it re-written in such a way that there is no lack of clarity with regard to the drug, its dose and its frequency.

Incident No. 13

In this incident, a staff nurse administered 30mg of Dihydrocodeine; having checked that the last time the drug had been administered was six hours previously. When the nurse then went to sign the kardex, she realised that another nurse had given the patient the same drug 30 minutes beforehand whilst she had been in a different area. This had not been recognised at the time as it had been signed having been given in a column headed “Other Times”. On discovering the error, the nurse contacted the relevant medical staff and manager in order to report the problem. It is noted by the staff nurse “at no time did the patient suffer any ill effects from having Dihydrocodeine 60 mg instead of 30 mg.”

The manager, having reviewed the statement submitted by the staff nurse, asked that the charge nurse in the ward arrange to check the practice of the staff nurse involved on two separate occasions on all aspects of the administration of medicines procedure. The manager also requested the charge nurse to confirm in writing that the charge nurse was satisfied that the nurse was conversant with the appropriate policies and procedures. Within the classification outlined within chapter II this would be regarded as a rule based error.

There is no evidence within the documentation that this assessment was undertaken, or that the charge nurse had satisfied herself that the staff nurse was clear on the appropriate policies and procedures. The other area to note with regard to the available documentation is that an incident form was available although it was for a different patient and a different incident although the same member of staff was involved. This was another example of documents relating to different incidents being apparently mis-filed as well as a lack of documentation confirming that appropriate agreed actions had been taken and proven to be effective. The impact of this lack of follow up was that the likelihood of a recurrence was not reduced, which should be, and was the stated aim, of the risk management policy within the organisation.

Incident No. 14

This incident involved the management of an emergency situation within a ward and how it was affected by other incidents elsewhere within the hospital. The incident under investigation involved the sudden deterioration of a patient which merited an emergency call, known as a fast bleep, for anaesthetic assistance. This was very shortly followed by a request for the cardiac arrest team to attend the ward. However, the cardiac arrest team were within accident and emergency area, resuscitating a patient who had been brought in by paramedics. In a very short period of time, i.e. 6 minutes, a third request for the cardiac arrest team was made from another ward. The situation was therefore 3 emergency calls in different area of the hospital, all requiring the attendance of the cardiac arrest team. Within the classification outlined within chapter II this would be regarded as a skill and rule based errors.

This, in itself, was a very unusual set of circumstances and one which the organisation's Resuscitation Committee took some time to review and identify any recommendations which could be made should it happen again. However, the incident under investigation had a number of other aspects which resulted in a less than optimal management of a cardiac arrest situation in a ward. In the report, a number of these areas were outlined:

1. Maintenance of the Ward Management Equipment

"The emergency equipment within the ward was not maintained to a satisfactory level"

- Emergency equipment not checked regularly
- Several staff unfamiliar with the working of vital equipment. This
Included wall and portable suction, oxygen cylinder, defibrillator
- Essential resuscitation items were missing from the trolley
- The Ward trolley appeared unclean and dishevelled

2. Resuscitation Training of Nurses

"There were a total of 3 qualified staff on duty within the ward at the time of the incident. Ward (name) had been closed the previous hour and a very experience staff nurse also came to assist. In addition, the directorate charge nurse attended. Much criticism has been made of the direct skills displayed on the whole by the ward nursing staff. It would, however, appear that the lack of leadership at the arrest contributed to what then appeared to be poor performance from the staff".

The investigation into the incident was commissioned by the nurse manager for the area and undertaken by the resuscitation-training officer. In his / her report, the resuscitation training officer noted a number of specific problems within the area:

- "1. Cardiac arrest trolley poorly stocked – ward had not followed stock guidelines issued or used agreed check sheets. The cardiac arrest trolley was rarely checked. Ward staff were unfamiliar with the layout of the trolley. The portable suction machine was not complete and fit for use. Staff were unfamiliar with its use. Oxygen cylinders were not full and ready for use. There appeared to have been a lack of responsibility taken for checking the emergency supplies on the ward.

2. Nursing attendances at resuscitation training from Ward (name) was very poor with no staff attending since (date) [one year prior to the incident]. (Two nursing staff had booked in for training in (date), but the class was cancelled due to poor numbers).
3. Even at basic level, there seems to have been an apparent lack of will from the nurses present to be involved in delivering CPR.
4. There was no sense of priority with poor ability to complete one task prior to distraction by another. This led to significant delays in the early stages of resuscitation.'

The resuscitation-training officer goes on to summarise a number of more general problems, i.e.

- "1. The team in Ward (name) were unaware that the cardiac arrest team were on Standby in A & E. When there appeared to be a delay in the Arrest Team arriving, panic seemed to affect staff present in Ward (name). Sufficient staff were present so that one could have gone to the next Ward and got the defibrillator to enhance the early stages of resuscitation. Initially, there was a lack of recognition by medical and nursing staff that the patient's condition was deteriorating so seriously. No one took control.
2. There appears to have been a failure to summon the emergency team at the earliest stage.
3. There appears to have been an error in the telephone exchange in calling the junior surgical team to the arrest. (Name) is reviewing this.
4. Nurses did not complete tasks they were asked to fulfil. Medical staff lacked sense of priority and direction.
5. Lack of leadership initially when the nurse found the patients condition deteriorating and secondly when the medical staff took over the management of the event.
6. Communication throughout the whole situation was very poor. There was no spirit of teamwork, the surgical and medical doctors did not communicate clearly with each other, leading to a grave lack of clarity regarding the patients management."

The resuscitation-training officer then goes on to make a number of comments about the situation and recommendations for the future.

Having received the report, the general manager for the directorate requested that the points of action outlined in the resuscitation training officer's report be actioned. The report within the documentation clearly identifies all actions taken for each of the issues raised within the resuscitation-training officer's report. The nurse manager details at the end of her report,

"in conclusion, this incident highlighted a number of points for all staff, not only the nursing staff of Ward (name). Unfortunately, this incident has been discussed widely throughout the directorate prior to all information being established, and has resulted in misinterpretation of the factual information later presented".

This final comment in the nurse manager's report illustrates a problem with any clinical incident in that there can be considerable discussion in the area with regard to the incident which, in turn, influences some of the information which is made available. This can result in a lack of completeness, or indeed, accuracy of some of the details which, in turn, makes appropriate recommendations and action for change difficult.

This incident demonstrates how a number of different apparently unconnected sets of circumstances come together and contribute to the overall situation. The fact that the emergency team is required in three different parts of the organisation at precisely the same time is by any standard a rare occurrence and one for which it is not sensible to plan. It would be impractical in the extreme to suggest that there should be three emergency teams available at all times. When to this fact is then added the apparent failures to maintain equipment, a lack of appropriate equipment to deal with the situation in hand, failures in communication, lack of leadership, and lack of appropriate training it becomes clear that the incident had the potential for a disastrous outcome. As individual difficulties they may have had little impact on the overall situation however having been brought together the effect was greater than the sum of their parts. Miller (1992) argues that a similar list of 'failures' (equipment, training, communication and leadership) were

responsible for the eventual demise of the Titanic following its collision with an iceberg mid-Atlantic.

DIRECTORATE II

The documentary evidence available for the clinical incidents within this directorate was very different from that available from the first directorate. The first set of documents is a summary of 11 incidents, 8 of which affected a patient, and 3 of which affected a member of staff. The document is headed up “Incident Reports Further Investigations” and suggests that these incidents warranted some further investigation beyond the completion of an incident form, although none of the incident forms were available. Basic information included the date of the incident, the ward, the person involved, the type of incident and any information and/or comments. These are summarised as follows:

- Incident 1 involved a patient who fell and the comment made being “staff trying to be more vigilant and remind patient not to attempt mobilising without help”. Within the classification outlined within chapter II this would be regarded as a rule based error
- Incident 2 involved a patient who had a burn or a scald. “No bed-making during patient meals. Two members of staff to turn mattress.” Within the classification outlined within chapter II this would be regarded as a skill based error.
- Incident 3 involved a patient who fell, comment is “cot sides already up and cot supports e.g. bumpers in place”. Within the classification outlined within chapter II this would be regarded as a rule based error.
- Incident 4 involved a patient who was being aggressive. “No psychiatric referral made, was on Chlordiazepoxide regime due to excessive alcohol intake. Also

prescribed Haloperidol. Medication had no effect that evening, settled and causing no more incidents.”

- Incident 5 was a patient who clearly fell. Comment made “hoist taken out of circulation, reported to Estates, reinforced to staff involved Health and Safety issues”. Within the classification outlined within chapter II this would be regarded as a rule based error.
- Incident 6 involved a member of staff who sustained a strain/stroke sprain. “Felt right increase painful, sent to A & E. X-rayed, sprained wrist strapped and sent home”. Within the classification outlined within chapter II this would be regarded as a skill based error.
- Incident 7 involved a member of staff who slipped. “Domestic Supervisor contacted. When Domestic asked why there was no warning sign, reply was ‘It’s not my fault there are not enough signs. Speak to Domestic Supervisor’”. Within the classification outlined within chapter II this would be regarded as a rule based error.
- Incident 8 involved a patient displaying an irate manner towards staff. Comment made “Agreed to advise medical staff re her concerns about discharge planning”.
- Incident 9 involved a patient who was confused and became abusive. Comment made “At the same time as this happened, the doctor and myself were seeing to an acutely sick patient who required Diamorphine. I was on my way to get this when the incident happened. The Registrar heard the commotion from the doctors’ room and came to help. Because we then had to restrain him and get security, there was a delay in getting Diamorphine for the other patient”.
- Incident 10 involved a member of staff with right hand and wrist injury. “While transferring a patient to the Stroke Unit, we had to use lift. The level of the floor

was uneven, Staff Nurse (name) and myself were entering lift with bed and mobile drip stand. The drip stand wheel was caught whilst moving into lift and my hand was caught between the bed rail and drip stand". Within the classification outlined within chapter II this would be regarded as a rule based error.

- Incident 11 involved a patient who became aggressive. "Five of the night staff have done the dementia training. Day staff did have problems, logged as incidents. One patient was particularly confused, demented and aggressive, she was getting "specialised" when her behaviour was bad at her usual nursing home".

The information relating to the above incidents was incomplete in terms of the requirements laid out within the policy framework. In relation to this particular study, there was no further information which the researcher could follow-up and therefore the documents relating to the incidents could not be examined any further, and the staff involved could not be contacted to take part in the interviews.

The researcher was keen to explore why documents relating to these incidents had not been completed or retained in the same way as others. One explanation offered was that the manager involved at the time of these incidents had subsequently left the organisation and it was thought that these had probably been destroyed whilst that individual was clearing their office. Given the requirements for storage and maintenance of these records in place at the time, these should not have been destroyed, but retained within the organisation for a period of time.

The next 6 incidents all related to drug errors and, once again, the documentation available for each of these incidents was incomplete. The available documents for each of the incidents varied, but all related to some form of investigation/disciplinary action.

Incident 12.

The only document relating to this was a letter to a member of staff indicating that a meeting had been arranged to investigate an alleged drug error, and informed the individual that

‘As the investigation may lead to a decision to proceed with disciplinary action, you are advised of your right to be accompanied by a Trade Union or Staff Organisation Representative, or a friend.’

Although there is no detail as to the nature of the drug error within the letter to the member of staff it is clear that the process being employed to investigate the issue was the disciplinary process. This would appear to be the preferred method of the manager in post at the time although this changed when the manager changed and a more reflective, less punitive approach to the investigation was utilised.

Incident 13.

The documents available relating to this incident included the letter asking the member of staff to attend an investigative meeting, a letter indicating to the member of staff the outcome of the same meeting and a copy of some drug documentation relating to the incident. Within the classification outlined within chapter II this would be regarded as a slip and a skill based error. The outcome of the meeting was communicated to the member of staff as

‘After an adjournment to consider the evidence, we reconvened and I indicated that we would not proceed, in this instance, any further. We have agreed to review our procedures and education practices in light of this situation and will set up a review in the near future.’

In the letter sent to the member of staff following the investigative hearing, the charge nurse who undertook the investigation concludes

‘We met to investigate the circumstances, which led to (patient name) being given the wrong dose of insulin via an infusion device. I outlined the case, I explained that the meeting was held to accord you the opportunity to state your case and for me to establish the facts.’

In this particular incident, the “investigation” was conducted by charge nurse who was accompanied by a more senior manager and was therefore clearly a learning opportunity for the charge nurse as well as a formal investigation. Included within the documents were a number relating to the incident, including a prescription sheet, drug infusion chart and a diabetic chart. Within these charts there are a number of issues relevant to the investigation.

Prescription Sheet

The prescription sheet has no name and no unit number for the patient and therefore it is difficult to see how nursing staff were able to relate these prescriptions to an individual patient. In the section marked ‘parenteral medicines’, there are four medications prescribed; one having been scored out on the same day it had been prescribed. For one of these drugs, the dose is marked as “3,500” but no units identified. In the section marked ‘parenteral medicines’, once-only prescription, a single dose of Augmentum is prescribed but there is no indication that this had been given, and there is identified within this chart, a sliding scale of insulin to be delivered according the patients blood-glucose readings. There is one set of rules for the insulin infusion rate which have been crossed-out and substituted by another, none of which has been signed by the prescriber.

Drug Infusion Chart

This chart requires a number of pieces of information relating to the patient; the patient’s identity, i.e. unit number the patient’s ward, the pump type, serial no. and the date – all of which were available and completed within the chart. It also requires the name of the drug, the concentration, the diluent fluid and the information relating to the prescriber. In this pro-forma, the diluent fluid was missing as was information relating to the prescriber. It was also noted that the date requested does not tie in with the date on the prescription sheet.

Diabetic Chart

This requires the patient’s name and identifier, i.e. unit number and ward. Name and ward is available, but not the unit number. The chart requires the blood glucose level to

be monitored on a pre-determined time-scale. Some of these are missing. It is noted that although the insulin doses are recorded, there are no initials to confirm whether or not this had actually been given and to identify the administering nurse.

From the documentation available relating to this incident it is clear that the individual nurses involved were the subject of the formal investigation during which it was evident that the issues requiring to be addressed related to what the manager described as 'procedure and education practices'. Whilst these are not specified by the manager it is clear from the lack of information contained within the charts described above that the accepted normal practice required to be addressed. It may be deduced that the charts did not contain the required information to identify the patient. Despite this the charts were used by different staff on a number of occasions and was therefore usual practice. This is despite the fact that being able to match individual prescriptions against each individual patient is a prerequisite to being able to administer medication safely.

Incident 14.

The only document available for this incident is a letter to a member of staff, asking them to attend a meeting to investigate an alleged drug error.

Incident 15.

The only document relating to this incident is a letter to a member of staff confirming the outcome of an incident. The document itself contains a brief description of the incident under investigation

'We met to investigate the circumstances which led to (patient name) being found dead in bed at 7.30 am. The post mortem showing that he had died at 3.00 am. We met to establish the facts. You admitted (patient name) had asked not to be disturbed, you have not checked him in the morning stating he was self-care.'

Having done so, the manager then goes on to record the outcome of the investigation as

‘After an adjournment to consider the evidence, we reconvened and I indicated my intention not to proceed, in this instance, any further. You have, however, as a result of this case, reviewed your systems and now confirm to the day staff, on handover, an up-to-date report for all patients.’

The reason for the investigative meeting appears to be the fact that a patient was found dead in his bed at 0730, a post mortem having established that he died at 3am. It is difficult to identify what ‘error’ merited the instigation of a formal disciplinary process against a nurse. There is no indication as to the cause of death. There is no suggestion that the death was as a result of any act of omission or commission on the part of the nurse, other than the nurse did not check him between 0300 and 0730. The nurse commented that this was due to the fact the patient was ‘self-care’. There may be a reasonable case to understand the actions through the night it appears to be an excessively punitive process to subject a qualified nurse to a disciplinary process in order to obtain such information. Hypothetically, what would have been the case if the nurse had checked on the patient at 0245 found him to be asleep and as there was no need to check him again until the morning did not check him again until 0700 then the result would still have been the same i.e. the patient would have died at 0300. It is difficult to see what the review of systems suggested within the letter was likely to suggest to prevent a patient dying between checks by a nurse.

Incident 16.

The only documents relating to this incident are a letter to members of staff asking them to attend an investigative meeting to “Investigate a drug error”. It also contains a letter recording the outcome of said meeting. The manager, in the letter outlining the outcome of the meeting, gives a brief description of the reason for the meeting, being

‘We met to investigate the giving of (patient’s name) drugs to (different patient’s name). I outlined the case against you, that you dispensed the drugs, did not follow procedures, did not check arm bands, and gave drugs to (patient’s name) which belonged to (different patient’s name). I explained that the meeting was held to accord you the opportunity to state your case, and for me to establish the facts.’

Having outlined the reason for the meeting, the manager then goes on to identify the member of staff's explanation provided on the day

‘You admitted that you had been on (Ward area) unusually for you, and you felt there was a lot going on in the ward and you had been interrupted a few times. You realised you were not concentrating, you apologised.’

Having outlined this position as presented by the member of staff, the manager then goes on to identify the outcome of the meeting

‘After an adjournment to consider the evidence, we reconvened and I indicated my intention not to proceed with disciplinary action. You have learned a valuable lesson, however, and are well aware of the potential danger to the patient.’

In this incident the nurse involved presented a number of explanations for what are technically violations in that the nurse failed to follow basic procedures in order to ensure medication is administered safely. Given that there may also be described as a slip or lapse in that steps were either taken or not as a result of distractions. Despite this there appears to be no specific action required of the nurse as a result of the incident. It was noted by the investigating manager that the member of staff had learned a lesson however there was no indication of a period of supervised practice to establish the level of competence of the individual in question, as was the practice elsewhere within the organisation. Arguably if the nurse was ‘willing’ to violate the accepted procedures for the safe administration of medicines in the ward in this case (which was not the nurse’s normal ward) then the same procedures would be violated elsewhere. Within the classification outlined within chapter II this would be regarded as a slip.

Again, it would appear that a number of different pieces of documentation relating to this error were not available. Once again, on seeking clarification, the researcher was informed that the manager involved in this incident had since left the organisation and these were the only remaining documents.

From the documents relating to the drug errors, there are a number of points of interest and worthy of further consideration:

- In some letters asking members of staff to attend an investigative meeting, the incident is described as “an alleged drug error” whereas in others it is described as “a drug error”. There appears to be no differentiating between what is an actual error and an alleged error. The term alleged would normally be used until the investigation was complete and had confirmed that an error had been committed. The lack on consistent terminology in relation to the incident management does little to instil confidence in the process and its integrity.

- In two separate incidents, they are being used as a learning exercise for a more junior member of staff. However, in one, the more junior member of staff takes the lead and, in the other, the more senior member of staff takes the lead. The documentary evidence would suggest that each of the novice managers were at similar levels of experience in this field of managerial practice. Whilst it is accepted that novice managers have to become familiar with the relevant management processes it seems that there is a lack of consistency in the approach being adopted and there is no acknowledgement to the member of staff involved the reasons for the apparent differences from the stated policy.

- None of the incidents appear to involve any advice from professional pharmacy staff. It is accepted that many medication errors are very straightforward and the involvement of professional staff would add little value to either the understanding of the error or to the investigative processes. However, in at least one of the incidents described above (incident 13) there are a number of complex interactions and arguably the involvement of a pharmacist would have been an important part of the learning process.

- Only one of the incidents identifies any changes to current practice in the organisation and one relates to an individual’s change in practice. This demonstrates that this part of the organisation was not using such incidents as

learning opportunities nor was it sharing the potential lessons with the wider organisation.

- Although all incidents were apparently managed under the disciplinary policy, no disciplinary action has been instituted. This brings into question the need to use this policy to manage this situation. It is recognised within the literature that the use of the disciplinary process can have a very negative impact on the individual's confidence and belief in their own practice and as such could in itself be a contributing factor to any subsequent error.

A different manager to the one who managed incidents numbered 1-16 in Directorate II has managed the incidents described hereafter. There are some notable differences not only within the processes employed but also in the stated outcomes of the incidents. These will be illustrated within each incident.

Incident 17.

The documentation for this incident is very different from any of the others. It consists of a statement surrounding the incident from a qualified nurse who made the error and a qualified nurse who discovered the error. The third piece of documentation is described by the individual involved in the incident as a 'reflection of the incident'. It outlines the incident in some detail whereby the nurse administered a diuretic to the wrong patient. The nurse then describes the feeling and the actions taken

'My whole body sank. It felt like I was falling a great distance without going anywhere. I was the most terrified I had ever felt (this from a man who has jumped from aircraft, climbed down buildings, raced motor cars, jumped off cliffs and bungee-jumped). A horrible feeling, a wave of nausea and of panic. It felt that time had stood still, one terrible moment of stillness. Then the training kicked-in. I informed the patient, spoke to the JHO, Junior House Officer, and SHO, Senior House Officer, and Nurse in Charge.'

Then followed the documentation of the event.

I then had to continue with the rest of the patient's drugs, a nerve-racking experience, with me taking more than necessary steps to ensure the right patient got the drugs. I was like a man obsessed: name, unit no, name, unit no., check name band, check unit no., an unending series of name, unit no., name, running through my head. It felt that my soul had been sucked straight out of me, a vacuum filled my heart.

The staff nurse then goes on to describe further feelings as well as identifying where he felt he had gone wrong, how it could be addressed, and what he had learned, and concludes

'This incident has made me very aware of the power a Staff Nurse has, and the responsibility that goes with it. A very potent reminder and something I feel the University failed to stress and something which you don't experience as a student.'

There is no evidence amongst the documentation that there was any formal investigation into this incident, but that the manger had taken an approach allowing the individual nurse to reflect on the situation to identify the circumstances surrounding the incident, what had gone wrong, and how this could be prevented. Although the individual involved in the incident identifies a number of objectives for himself, there is no evidence that these had been formalised and achieved. The nurse involved also raises an important issue within the reflection with regard to the role of the pre-registration education and its relevance to preparation for practice, post-registration. In the reflection the staff nurse states that this is one part of professional practice not adequately covered by the university and not something normally experienced as a student nurse. This would be valuable feedback to the educating body but there is no evidence that this was shared and therefore yet another opportunity lost to learn from an incident. Within the classification outlined within chapter II this would be regarded as a skill based error and a slip.

Incident 18.

In this drug error, the correct drug was given to the correct patient, but at the wrong time. The documentation includes an incident form, a brief statement from the individual who discovered the error, the patient's drug kardex and a hard copy of an e-mail between two senior nurses regarding the issue. The patient's prescription sheet identifies 8 columns

for times of administration, 4 of these columns have pre-determined fixed times, and 4 are blank to allow for variations. One of the drugs was due to be administered between two of the fixed points. This was recorded on the drug kardex by an additional time being identified with an arrow added, indicating between the two fixed times. This was felt to be the root cause of the problem. Within the classification outlined within chapter II this would be regarded as a skill based error. The copy of the e-mail identifies three main actions to deal with this incident:

1. The clinical director was made aware of the issue and asked to address the concerns around correct prescribing. The clinical director also made a suggestion with regard to how this could be prevented in future.
2. The pharmacist to be advised of the incident and to be invited to comment on the clinical director's suggestion for improvement. A senior nurse to be informed that the incident could be highlighted via the clinical governance structure.

This incident once again demonstrates the inter-relationship between the individual prescribing the therapy, the individual administering the therapy and the tools available to ensure that the symbiotic relationship remains a safe one. In this incident the need to involve the professional pharmacy staff is recognised at an early stage. The error has resulted from the prescriber attempting to adapt the prescription pro forma to accommodate a requirement, which does not fit the predetermined regime. Those who were expected to administer the drug using the same prescription pro forma were not aware of the prescriber's intentions.

Incident No. 19

The documentation relating to this incident, an alleged drug error, includes the patient's drug prescription and recording sheet, an extract from the patient's medical record, statements from the two nurses involved in the incident, a statement from the senior nurse to whom the incident was reported, a copy of the incident report form, a copy of a letter informing the member of staff involved in the incident of an investigative meeting, a minute of the investigative meeting and a letter to the member of staff outlining the outcome of the investigative hearing. Therefore, for this particular incident, there is a

complete set of relevant documents. Within the classification outlined within chapter II this would be regarded as a skill based error.

In this incident, a patient was due to receive an oral analgesic, a controlled drug. The two members of staff on duty checked and measured the quantity of drug required using a syringe rather than a small medicine cup as the volume required (2.5 mls) could not be accurately measured within a medicine cup. Both nurses then took the medication to the patient in order to administer it. As one of the nurses was bending down to lower the cot sides, the other nurse proceeded to inject the medicine into the patient's intravenous venflon. The non-administering nurse then noticed the error and quickly told the nurse to stop, however, the majority of the 2.5 mls had already been injected. The result of this was that 2.5mls of a solution which was intended to be taken orally had been injected into a patient's vein.

The incident was reported immediately to a member of the medical staff who was available in the area who asked that the intravenous venflon be removed from the patients arm and reassured both nurses that it was unlikely that the patient would come to any harm. The situation was reported to the consultant on-call who agreed with the advice given by the junior member of the medical staff. The two nurses then reported the incident to the senior nurse on duty who ensured that the relevant action had been taken and asked both nurses to complete the incident form and to write formal statements regarding the incident.

Both nurses state within their written accounts of the events that the incident was recorded in the patient's record. This is verified by inspection of a copy of the record included in the documentation. However, in the minute of the investigative meeting, it is reported that the member of staff's representative requested that the meeting note "that the medical staff did not feel the need to write on the patients notes". It is unclear why this point is being made, given that the nursing staff record in their accounts that the incident was recorded within the patient's notes and there is no suggestion from any of those involved that the medical staff had instructed that it should not be within the

medical record. However, the part of the patient's note which was available within the documentation set relates to nursing information as opposed to medical information, and this may account for any discrepancy. It is notable that the staff representative raised this as an issue. Given that the error related very much to nursing practice and was recorded in the relevant nursing documents, it is unclear why the representative would raise this issue as part of a nursing investigation other than to potentially illustrate the difference in the approach between how medical and nursing staff are managed during such incidents. This is an issue which has been noted in a number of areas. However, in this particular incidence, there is no suggestion that the medical staff were in any way involved in this incident.

During the investigation, the nurse involved, i.e. the nurse who administered the drug, was given the opportunity to outline the events of the incident. The member of staff and her representative were given at least two further opportunities to identify any particular issues which they felt were pertinent to the incident. The manager leading the investigation also sought clarification as to whether or not there were other things happening in the area, which may have caused some difficulty, "(name) asked if there was anything else about the ward that night". It is clear from this that the manager is attempting to establish whether or not there were any mitigating circumstances which might have caused the nurse to make such an error. The nurse involved replied,

'(Name) asked if she meant was anything distracting her. Stating no, that there had been one sick patient, but they were not focussed on anything else. She outlined that she had already administered drugs by IV and they administered a lot by IV in (ward name). However, she stated that this was not an excuse.'

The meeting then adjourned and reconvened indicating that the manager's decision was to proceed with disciplinary action. At this point in the proceedings, the member of staff and their representative are offered an opportunity to delay such process or whether they wish to have it completed there and then, and they said they wished to have no delay. The outcome of the deliberations was that the nurse should receive a verbal warning for her actions. This was confirmed in writing soon after the meeting.

This incident throws into high relief a number of issues of interest in the research.

- The documentation available with regard to this incident appears to be complete in relation to the incident itself although the details of the investigative process in relation to the second nurse are not available and there is no evidence that this actually took place.
- The patient had three separate prescription sheets; two of which had been completed with the patient's name, unit number, age and consultant, but the third, which was a continuation sheet, had no patient identification recorded. This would confirm some findings within the literature that the consistent and frustrating conclusions in any study examining nursing records is that they remain incomplete.
- It would appear that both nurses involved in the incident received a letter inviting them to separate investigative meetings. However, the documentation pack only includes a minute from one of these meetings as well as the outcome to one of these meetings, i.e. to the member of staff who actually administered the dose incorrectly. There is no documentation or information available to understand why this was the case.
- This is of particular relevance as the investigation of the first nurse led to disciplinary action. The only indication as to why this incident should have resulted in disciplinary action was what the manager described as the 'potential seriousness of the actions taken'. This would appear to be consistent with some findings within other studies whereby punishments given to nurses related either to the seriousness or potential seriousness of the outcome. Given some of the other incidents described above there appears to be little to differentiate this from other incidents and as such illustrates a lack of consistency in determining the outcome of such investigations.
- During the investigative hearing, the staff representative makes an issue of the medical staff apparently not feeling the need to write in the patient's notes. This illustrates two issues previously outlined in this study and within the literature; the

difference in approach to the management of incidents in relation to doctors and nurses and the inter-relationship between these two groups of staff.

- There is no indication that there was any requirement for any further educational support in order to prevent a recurrence. This is despite the different approach adopted by the new manager in this directorate.
- There is no indication that the lessons learned from this incident are shared either within the directorate or across the organisation.

Incident No. 20

The documentation relating to this alleged drug error included a handwritten version of events from the nurse involved in the error, the incident form, the patient's prescription sheet, drug recording sheet and record of some e-mails. In the statement, there is no indication as to the exact nature of the drug error, other than an incorrect dose, i.e. there is nothing to suggest whether the dose was too small or too large. It is recorded on the incident report form that a larger dose had been given than had been prescribed. The statement from the nurse spends a significant amount of time identifying the circumstances in which they were attempting to dispense medicines safely.

"I work in a 30-bedded (type of ward) on night duty. Two trained staff and one NA cover the ward. On the night in question, I was attempting to dispense the medication accurately in bay 4 in (ward name) in order for patients to have their medication and enable patients to settle for the night, and enable myself to move to the next 6-bedded bay and 2 side rooms under my care. Unfortunately, the bay was very busy with confused patients, patients climbing out of bed, patients becoming distressed at lack of attention. As staff nurse and NA were busy at the other side of the ward, I was trying to dispense medication and attempting to assist distressed and confused patient at the same time. I also had to answer several telephone queries regarding patients in my care. Due to these circumstances, I unfortunately dispensed the incorrect dose of medication to (patient name)".

There is no documentary evidence that this incident was followed-up in any way in terms of an investigation or discussion with the individual. It is clear, however, that the demands upon the individual were such that they distracted them from safe

administration of drugs and as such would be described in a technical sense as a lapse. The documentation illustrates some of the difficulty regarding the use of descriptive text in that some important detail is not recorded. In this instance the text does not record the nature of the incorrect dose (i.e. that the amount administered was greater than that prescribed). Within the classification outlined within chapter II this would be regarded as a slip.

Incident No. 21

The documentation relating to this alleged drug error is a summary of the events from the senior nurse to whom the incident was reported. A staff nurse, whilst coming on duty, was checking a patient to discover that an infusion of a medication had been diluted in 50% Dextrose, rather than 5% Dextrose. The infusion was labelled and signed by two members of staff who had been on duty the night before. The appropriate action was taken on discovering the error, i.e. the infusion was stopped and replaced with the correct diluent, patient was observed and blood taken to check for plasma glucose levels. Advice was also sought from relevant medical staff and pharmacy staff. The documentation pack did not include any further information in the form of an incident form or statements from the two members of staff involved. A senior nurse, however, reports that

‘Both staff have been asked to do a report on the incident with reference to the key points regarding the correct checking procedures, UKCC Guidance, and what they have learned from the incident, and what steps they will take to prevent a repeat occurrence. We have discussed where and how the error arose.’

The senior nurse to whom the incident was reported was also concerned that there was a lack of consistency in the recording and monitoring of such incidents and concludes her report by stating

“I feel that there is no consistent documented guidance regarding how this incident should be handled and would welcome some form of draft protocol. I also feel it is critical that we have a system to record and monitor these incidents at ward and directorate level in order to analyse and identify what the issues and training needs are”.

It has been suggested that having two nurses undertaking the checking procedure does not offer any greater guarantee of accuracy. This incident demonstrates this to be the case. The comments made by the senior nurse also demonstrates the already noted lack of consistency in the management of clinical incidents at a local level.

Incident No. 22

The documentation relating to this incident takes the form of a review meeting involving senior nurses, pharmacist, risk manager, health and safety manager and other relevant staff. The review itself was described by the senior nurse calling the meeting as a critical incident review in relation to the incident and was noted as

“Last Monday/Tuesday an incident occurred within the (name) directorate which had a domino effect on several other patients in two other wards. The impact was detrimental to patients and nursing staff and the outcome was less than favourable”.

An incident occurred in one ward whereby a patient was verbally and physically aggressive towards members of the nursing staff. He was allegedly suffering from alcohol withdrawal, which appeared not to be effectively controlled by medication. It was decided that he should be transferred to another ward where a side room would be available, thus minimising the disruption to other patients. In order for this to happen, a patient within the receiving ward had to be boarded to yet a different ward. The patient who was thought to be the most suitable, was one who was due to be discharged the following day with a complex discharge package arrangement. The day following the incident, two patients were due to be admitted but, due to a lack of beds, they could not be admitted immediately and some bowel preparation was commenced with one patient prior to a bed being available and, having agreed to use one of the patients' toilets, was unfortunately incontinent in a communal area. The nursing staff involved with the first patient, i.e. the individual suffering from alcohol withdrawal, felt that the medical management of symptoms was less than optimal and did not follow the available guidance for the management of such agitated patients, and this contributed to the “domino effect” on this other incident.

The patient who had to be boarded out of his ward to accommodate the agitated patient had in place a complex discharge plan which disintegrated as a direct result of the patient being moved from one ward to another. The review of circumstances noted that

“The discharge facilitator went to ward (name) to discuss with the nursing staff the following discharge planning arrangements:

- Informed medical staff that (patients name) was now on Ward (name) and required a medical review and a discharge prescription
- Re-routing the ambulance
- Informing diabetic specialist nurse of discharge plans
- Liaising with a social worker, district nurse liaison officer and pharmacy department”

The review then goes on to note that, as a result of the patient being moved from one area to another, the following sequence of events led to an undesirable discharge:

- Although his discharge prescription was written and signed by a doctor, it was incomplete and was dispensed with some of his drugs missing.
- The diabetic specialist nurse did not arrive until the afternoon. The ambulance came early and (patient name) left without seeing her. Consequently, he had no blood glucose monitoring equipment, no insulin syringes
- Information on immediate discharge letter unhelpful for new temporary GP
- Discharge facilitator spent 4 – 5 hours sorting out the mess along with district nurse liaison officer.

The nursing staff involved in all of these incidents reported that:

1. If patient A, who was agitated as a result of alcohol withdrawal, was being physically and verbally abusive to nursing, medical, other healthcare staff and potentially at risk to other patients had been managed adequately by the medical staff in accordance with laid down guidance for such circumstances, he would not have required to be transferred to another ward and therefore no need for patient B to have been boarded out.

2. Patient B's discharge plan which had been well-prepared and well thought out, had gone awry as a result of an inappropriate and unnecessary move of the patient from one ward to another
3. Patient C found himself in a very embarrassing and demeaning position, having been faecally incontinent in front of patients and relatives as a result of bed not being available because of the incident described above.

The action taken as a result of this sequence of events was:

1. Firstly the medical staff involved with the management of the patient with alcohol withdrawal symptoms were informed of the available guidance on the management of such cases.
2. That the protocols for the management of alcohol withdrawal should be reviewed.
3. Any decision relating to patients being boarded out within the directorate should be deferred to the most senior nurse available at the time whose decision should be regarded as a final one
4. Any member of staff concerned about a planned discharge should contact the discharge facilitator who is aware of all planned discharges.

The meeting concludes that the above actions were thought to have already been in place by some of the staff present but it appears that not all key staff are aware and that more work around this issue seems important.

This incident very clearly illustrates the potential effect that a set of circumstances can have on other parts of an organisation which would appear, on the face of it at the very least, to be completely unrelated. This is an issue which is described vividly in a number of pieces of literature whereby it should not be assumed that the final event is, in itself, the only set of relevant circumstances to the final incident.

The nurse manager concludes at the end of her report "... this incident highlighted a number of points for all staff not only the nursing staff of Ward (Name)" Unfortunately, this incident has been discussed widely throughout the Directorate prior to all information

being established and has resulted in misinterpretation of the factual information later presented.

This final comment in the nurse manager's report demonstrates a problem with any clinical incident in that there can be considerable discussion in the area with regard to the incident which in turn influences some of the information which is made available. This can result in a lack of completeness, or indeed accuracy of some of the details, which in turn make appropriate recommendations and action for change difficult.

The complexity of this incident only serves to illustrate once again how circumstances within one part of the organisation can impinge negatively on another and exacerbate the impact of an untoward incident even where they appear to be entirely unrelated. As described in a previous incident within a different directorate a number of different factors have come together to result in the outcomes described above. It would appear that similar 'failures' have all played a role – i.e. equipment, leadership, communication and training. Whilst the example cited by Miller in relation to the Titanic has been used there are other high profile incidents which have found similar issues for example the Piper Alpha oil platform fire and the explosion of the American space shuttle Challenger shortly after take off.

DIRECTORATE III

From this particular directorate, four incidents were presented to the researcher. The documentation relating to all four incidents took the form of critical reviews of incidents. These were:

1. An alleged sexual assault
2. Fire-raising incidents
3. A fire

4. Suicide

The exact nature of each of these incidents will not be described in any detail as it is likely to reveal the identity of the organisation which agreed to take part in the study, but which requested that the anonymity of the organisation and its staff be maintained. Therefore, the researcher took the view that these incidents should be commented upon in terms of the process rather than the incidents themselves. However the very brief title used above illustrates the nature of the individual incidents.

All four incidents took the form of a critical review. They were undertaken and led by a senior member of the multi-disciplinary team but involved all relevant parties. The final reports provide descriptions of the incidents, any relevant statements from those members of staff and/or patients involved, copies of relevant policy procedure and guideline information and any recommendations for future practice.

The format of the reports suggests that a different approach was undertaken by this part of the organisation to the others already discussed. They involved a wider group of staff including those who may not necessarily have been involved in the incident but who could nonetheless contribute to an understanding of its cause and how 'things could change to prevent a recurrence'. This wider, more inclusive approach reflects the type of clinical work undertaken within this directorate as well as the multidisciplinary style adopted in delivering such clinical care. Although the staff involved were not part of the interview process within the research the manager involved agreed to be interviewed and the views expressed are included in the analysis.

SUMMARY

The clinical incidents described within this chapter represent those reported through the subject organisation's recognised channel for reporting clinical incidents involving qualified nurses. There is a broad spectrum of incidents although the largest single incident type was medication errors. This reflects the finding within the literature and is

consistent with other studies. A number of issues have been raised through the analysis and include;-

- The application of processes within and between parts of the organisation is inconsistent despite being part of the same policy framework.
- The apparent inconsistencies between managers in the application of policies, the investigation and management of incidents and the eventual outcome of incidents was evident not only across the organisation but within single managerial units.
- The lack of use of learning opportunities within and between parts of the organisation was evident throughout the analysis. This in part was demonstrated by similar incidents occurring in the same area within a short period of time.
- The inconsistencies between different staff groups (mainly nurses and doctors) in the management of clinical incidents were also evident in a number of different incidents. This was in the main (although not exclusively) related to medication errors.
- The attribution behaviour demonstrated by some of the nurses involved in incidents and their explanations for the causes.

These issues are brought together in Chapter IX as part of the overall conclusions of the study and discussed further in chapter X as part of the wider discussion and recommendations.

Chapter VII

STAFF INTERVIEWS

Following the in-depth examination of the clinical incidents from the subject organisation, phase III of the research study was the completion of semi-structured interviews with those staff identified in phase II. The cohort of staff included the nurses directly involved in the incident, the nursing staff responsible for the management of the investigative process and any other relevant personnel implicated in the incident or its investigation. The final group of staff to be approached was representatives from staff organisations and professional organisations involved in supporting and representing staff during the investigations. The main purpose of these interviews was to investigate and understand individual's perceptions of the structure, process and outcome of the management of the investigation. In particular, this was an opportunity to explore with nurses involved whether they felt that the incident had been managed fairly and whether they felt that blame had been apportioned unjustifiably.

As outlined within chapter III, one of the limitations of the study is the potentially small number of volunteers prepared to take part in the study. This is due to the very sensitive nature of the topic under investigation and the impact it may have had on the volunteer. The researcher recognised that this form of self-selection had the potential to provide a bias in the responses. For example, there was a danger that those who volunteered may have a particular personal agenda relating to the incident or to the way it was managed. Having accepted this limitation, the researcher was able to guide the semi-structured interview to minimise the effect of any possible bias.

MAKING CONTACT

The researcher identified those members of staff to be contacted from each of the incidents examined in the phase II of the research programme. A total of 31 staff were contacted by letter. The initial contact served a number of different functions. The letter from the researcher introduced the researcher, outlined his background, confirmed the

permission received from the organisation and explained the outcome of the submission to the Local Research Ethics Committee. The letter also enclosed a consent form with a pre-paid envelope for the individual nurse to respond, and an information sheet outlining the aims and objectives of the study along with contact details of the researcher and the research supervisors should there be any questions the individuals wished to raise. Copies of this documentation are included in appendices 1 and 2. Relevant details, which could identify either the organisation or any individuals, have been omitted. Each subject was asked to complete a pro forma, confirming that they were prepared to take part in the study and the method by which they would prefer to be contacted, i.e. by letter, telephone or e-mail. Also included in the consent form was the option not to take part in the study and the researcher requested if this were the case, the member of staff explained why they would prefer not to take part in the study as it was felt that this would be potentially useful information.

RESPONSES TO INVITATION TO TAKE PART

In the first return 12 responses were received, of which 6 nurses agreed to take part in the study, 5 were not prepared to take part in the study and one had been returned as the member of staff had moved away. Some weeks later a reminder letter was sent to those who had not responded with further copies of the information sheet and consent form. Following the reminder letters a further 8 subjects agreed to take part in the study, with one other stating that they would not be willing to take part. The breakdown of the response rates are presented in table 8 below. An analysis of the responses is then provided in table 9

Table 8: A Summary of Response Rates

	Number	%
Number of nurses contacted	31	100
Total number of responses	20	64.5
Returned unopened	2	6.5
No Response	9	29.0

Table 9: An Analysis of Responses

	Number	%
Total number of responses	20	100
Willing to take part	14	70
Not willing to take part	6	30

It was felt important to ascertain why individuals did not want to take part in the study. A total of 6 (30%) subjects who returned their consent form stated that they did not wish to take part in the study. Four provided reasons and 2 provided no reason. The four reasons provided were :-

- Due to past experiences I would prefer not to take part in this study.
- Not prepared to discuss my clinical practice outside employment-related issues.
- Personal reasons.
- Feel as though I have been over said incident in full already - don't want to go through it again.

At the outset of the research it was difficult to predict how many nurses would be prepared to take part in this part of the study. Given the sensitive nature of the subject matter and the voluntary nature of participation it was anticipated that the response rate could be relatively low. The 14 staff (70% of respondents) willing to take part in the study provided an acceptable foundation for obtaining a spectrum of views relating the management of clinical incidents. As the number is relatively small it would be difficult to provide a breakdown between those who were managers and those who were staff who were themselves investigated without potentially compromising anonymity. However, within the cohort of 14 respondents there is a mix of clinical nurses, nurse managers and others involved in the process.

Each semi-structured interview was recorded using audio equipment with the consent of the individual member of staff and conducted in an open format in order to elicit as much qualitative information as possible with regard to the individual's perceptions of the

management of clinical incidents. Efforts were made to try and avoid an in-depth description of the incident, although perhaps this was inevitable. On some occasions interviewees took the opportunity to outline their version of events. The researcher developed a broad framework to ensure that all the relevant information was obtained. The structure and areas to be covered are outlined in table10

Table 10: An Outline of the Interview Framework

Area	Subject to be Covered
Structure	<ul style="list-style-type: none"> ➤ Policies ➤ Procedures ➤ People ➤ Culture
Process	<ul style="list-style-type: none"> ➤ Investigation ➤ Meetings ➤ System review
Outcome	<ul style="list-style-type: none"> ➤ Discipline ➤ Education ➤ System changes ➤ Wider learning

This framework was utilised by the researcher in each interview. By the nature of qualitative study it was neither possible nor desirable to follow a strict format of interviews. However, these were the main areas of investigation and as such the same framework was followed and utilised in undertaking an analysis of the data generated through the interviews.

STRUCTURE

The Perceptions of Policies and Procedures

The policy framework within which clinical incidents were managed had changed throughout the period of the study and the main areas of change have been described earlier. There were some very mixed perceptions about the usefulness of the policy documents used within the organisation. Not surprisingly the perceptions of investigators were different from the investigated. It was also clear however that within these two groups of staff there were different perceptions. Managers tended to use the policies as

flexibly as they could, some to the point where they almost ignored the policy completely. Some, who had never been involved in the investigative processes, previously, reported that they followed the policy closely.

‘It was helpful because I have never until that point been involved in an investigation of an error. People who were used to doing this were able to guide us through it and as it was a new policy the people who were involved in writing it were there and they helped.’ (Interview 4)

One manager stated

‘We tend not to follow it to the letter unless there is a real possibility of someone having to be dismissed.’ (Interview 1)

This individual manager then went on to describe the principles followed in undertaking an investigation. This suggested that the policies and procedures were ignored completely as they felt that they had a more appropriate, less threatening and more productive method of investigation. When pressed as to why they had adopted this approach and why others had not, they replied

‘I think that it is down to individual experience, confidence and abilities. It also depends on the culture and environment... I have a lot of experience in different areas and am very confident in my managerial style and approach and therefore have no difficulty in defending the approach I take. I appreciate that different senior nurses find themselves in different circumstances and environments, which don’t allow them to do things differently. I do think this is a very ‘nurse’ related issue and a product of how nursing has been managed over many years.’ (Interview 1)

This view was reflected by another manager who stated: -

‘I use the policy as a guide rather than as a set of instructions, which needs to be followed to the absolute letter. I think that the approach within the policy is very rigid and tends to lead you down a path you may not necessarily wish to go down. My predecessor took what I would call a very traditional nursing way of dealing with people who had been involved in an error, particularly drug errors where they have to undergo an investigation and potentially are disciplined at the end of the process. I

know that there are discussions to try and change this approach but it has been the way that nurses have dealt with drug errors for years and it is very difficult to get people to change their approach quickly.’ (Interview 2)

Nurses who have been subjected to the investigation process also reported different views of the usefulness of the policies. The view of the individuals tended to reflect their perceptions about the process and outcome of the investigation. For example one nurse who was disciplined at the end of the process, when asked if the policy was helpful, responded

‘Not at all helpful for me. They are designed to help managers only to find blame with whoever was involved in an incident. My trade union rep. tried to convince me that they were there to help me get fair treatment but they are only designed for one thing – to blame the person who has made a mistake and to discipline them or even sack them. They are written by managers for managers with no thought to how that makes the member of staff feel or what it might do to their career.’ (Interview 5)

Another subject had a significantly different experience and view of the process. They reported

‘To begin with I wasn’t even aware that the Trust had a policy for when something went wrong, but my trade union made sure that I had a copy before any meeting. To begin with, I did not think that they would be of any help because, as I said I had never been involved in this situation before. However, my trade union rep. talked me through what would happen and that was helpful. It was just as well they did because the investigative meeting that took place really didn’t follow what the policy said should happen.’ (Interview 8)

The changes in the policy framework had seen a significant shift over the course of the research and had moved away from relying on the disciplinary process to undertake investigations to one which was more open and used techniques from other industries (for example root cause analysis). There was a spectrum of views as to how this change had improved the process and outcome.

‘I think that this has gone down very well. I think in the first instance people were suspicious of it because an incident happens you write out your incident form you’ll look at your risk assessment of it and I think that some people because the risk assessment was being done think, there was a realisation from the employee where it had went wrong it was more clear cut because they were walking through it perhaps with a risk analysis or whatever.I would say readily using the incident form and risk register far better than they were even a year ago. The fear has gone. People don’t think that because something automatically has happened that they are going to be facing an investigative.’(Interview 3)

The changes in the policies and procedures also led to some confusion as to the processes employed within a given situation.

‘Some of them are a little bit ambiguous in as much as they don’t tell you which direction to take and I tend to look for a lead in that, and that would be primarily because of my newness to this role if you like. I suppose if you had done it in the past you would know which way to go, but for me, the last incident which I dealt with, was part of the investigative team if you like, or the co-ordination of the, other people, I took my lead from (name). However, some of my personal knowledge and knowledge of the area in which the incident happened, did come in very useful and the (organisation name) were involved as well and that was a bit scary in as much as I wasn’t expecting the, hostility, I think is the only word I can use.’ (Interview 7)

There remains however some confusion over the role this plays alongside the investigative process that is likely to involve a member of staff in disciplinary action. One manager, when asked specifically about the new policy and the root cause analysis process, argued

‘That gets fudged though – because the problem is, if someone could or should be disciplined that has caused a problem because before you have an open discussion about what went wrong using root cause analysis the union rep is saying we need to get the investigative out of the way first. They seem to be running in parallel but I am not sure they are tied together.’ (Interview 6)

Summary of Perceptions of Policy

The perceptions of the helpfulness of the policy framework were coloured by the nurses' backgrounds & experiences, the role the individual nurse played in the process and the outcome. Managers with more experience in their role and more experience in undertaking investigations tended to use the policy flexibly and as guidance rather than as a set of rules to which they must adhere strictly. Less experienced managers and those who had not been involved in the process previously tended to use the policy documents as a 'roadmap' to guide them through the process and to ensure that they were not caught out by procedural errors. One trade union was noted by a number of respondents to have a tendency to try and derail the process in favour of their members by identifying procedural errors committed by managers. As a result individual investigations were terminated and no further action taken. This approach and the differences in style evident between managers were acknowledged to potentially create a perception of inconsistency across the organisation. Whilst the issue of derailing investigations was mentioned by a number of respondents, there was no evidence within the incidents examined in phase II that this was a tactic employed by staff organisations. It is also clear that such an approach did nothing to assist the process of identifying the root cause of an incident and therefore facilitating a potential solution.

For staff who had been the subject of an investigation there were mixed views about the helpfulness of the policy. This ranged from accepting that the policy and procedure were fair although did not reflect what actually happened, through to a complete mistrust in the document itself, which they saw as being a management tool that was used to apportion blame irrespective of the cause of the error under investigation. The view expressed from individuals who represented staff during the process described the policies as fair but that there are occasions where the interpretation of the policy leads to inconsistencies in approach and outcome. This in turn created the perception that the processes are unfair and inequitable. One representative also reported

'Sometimes I would say ... at times they are actually more fair to the employee than to the management.' (Interview 3)

Generally, it was acknowledged that whilst at the time of the research there was very limited experience in using the new policy framework; it was helping to shift the emphasis away from a punitive process to one that allows an open review of an error. There was some concern about what happens when there is a requirement to follow both a root cause analysis of the incident and a formal investigative process of an individual's role within the incident.

Perceptions of 'The Culture'

In undertaking the interviews the researcher did not introduce the term blame at all. It was only explored further if raised by the research subject. All those interviewed raised the issue of blame and most referred to the 'blame culture'. There were three main areas explored in relation to blame.

1. The organisational culture and blame
2. The issue of nursing and blame
3. A blame free culture

The Organisational Culture and Blame

It was important to review this organisation as part of the wider culture within the NHS, it was neither useful nor possible to separate the two. It also became evident throughout the interviews that it was difficult to divorce the organisational culture and the wider perceptions and expectations of the general public. All of which had an impact on the individuals' perceptions of the culture.

It was generally felt that in the organisation there was a culture of seeking to blame individuals for errors. It was also accepted that this was a reflection of the wider NHS as well as political and societal views. There was a lot of anxiety about how the media and in particular the tabloid press used untoward clinical incidents to present sensationalised headlines. They rarely if ever presented all the facts and that in turn did not reflect accurately the true nature of the problem. This in turn led to some politicians being seen to jump on the bandwagon and to demand that full investigations are undertaken to identify who was at fault. None of the incidents reviewed in phase II had received any

interest from the press. A number of interviewees however were able to cite incidents from the subject organisation, which had received local and national press coverage. In their view these had been sensationalised in order to add interest to the story. One of the interview subjects was very clear in their views of the culture that had developed.

‘For example no matter what happens, no matter how trivial the incident is we are subjected to an investigative hearing which makes you feel like a criminal.’ (Interview 5)

The organisation’s culture in part reflects the way in which its leaders chose to lead. It was commented by two different interviewees that the demonstrated behaviours of senior managers within the organisation did not reflect the approach and style suggested within the different policy documents. Both these individuals had been involved in what they described as ‘serious’ clinical incidents. One of the incidents pre-dated the time period of the study and was therefore not included in the earlier phase of the research, however the reflections of the member of staff were pertinent but had to be viewed within the organisational culture at the time of the incident. The interviewee acknowledged that the culture had changed since that time.

‘The (name of post) was not at all helpful at the time of the incident. I was not directly involved although it happened in the area where I worked, so I could see what was happening from the sidelines. Staff were marginalized and some were even excluded. It was clear that not all the relevant information was being gathered and the wrong conclusions were being drawn as a result. The style and approach adopted by (name) really affected the way the nursing staff felt about the whole issue and it left a bit of a bad taste for quite a long time.’ (Interview 11)

The appointment of the risk manager and the changes in approach outlined within the policy resulted in a perceived change in the organisation’s culture, although one interviewee remained sceptical that the rhetoric within the policy was matched by observable behaviours among senior staff and in particular senior nursing staff.

‘The policy says all the right words about wanting to learning from errors and to support staff through the traumatic times but that is not always what

happens. If you happen to get a particular manager then that might be the case but I could name a few names of senior nurse managers who definitely do not take that approach and they have a reputation for being really hard when it comes to disciplining staff for their mistakes. Mind you I have also heard it said that managers who don't discipline staff are just a soft touch so I suppose they cannot win really.' (Interview 12)

The culture within the organisation was recognised as a major weakness in encouraging individual nurses to report errors.

'You go back 5 years ago, someone did something wrong. Some people were very honest and would hold their hands up. A lot I think was put under the carpet because there was fear of an investigative with a disciplinary. Some people are very, very scared in that they actually think that they are going to lose their job.' (Interview 3)

When this issue was explored a little further as to whether the changes which had taken place within the organisation had resulted in a change in the perception this subject's response was interesting

'I think now people, some people, still don't believe that, because some people still perceive fairness and equity to be chosen as to who gets fairness and equity.' (Interview 3)

From this individual's experience the issues relate not so much to blame within the culture but the fact that individuals are not treated consistently and fairly across different parts of the organisation. The issue of consistency across the organisation was raised by a number of the subjects. Again this related to both managers who were responsible for undertaking the process and individuals who were being investigated. There was evidence that managers were discussing their approaches with each other in an informal setting to ensure consistency between the managerial units.

'I think that in any structure any manager would try and maintain consistency at least within their patch and sometimes it won't be consistent everywhere else but you really try to be consistent and fair... To be honest |I meet up with my counterpart frequently and if there is any issues then we discuss them but it is very informal. That is how we

discovered the drug error issue because I was indicating that we had a problem in a certain area and she said likewise.' (Interview 6)

Summary of Perceived Organisational Culture and Blame

There was throughout a number of interviews comment that cultural changes had occurred not only as a result of changes in leadership and management approaches but also through changes in the approach taken by individual members of staff and staff groups. There was a view that nurses were no longer prepared to accept the position sometimes endured by an earlier generation of nurses. Qualified nurses were now perceived as having wider life experiences by the time they qualified and fewer were entering nurse education directly from school. The change from schools / colleges of nursing often physically and culturally embedded within hospitals to academic faculties within universities has broadened the experience of students. Many student nurses are entering the profession at a later stage and bring a more mature approach to the culture and rituals within nursing as a whole. They are less likely to accept instruction in an unquestioning way.

'I think there's probably been a general change in the culture. I think people are much more happy to say I can't do that because I haven't had the training now, and certainly from a nursing point of view I think that is happening currently.' (Interview 9)

'We've also got a younger generation as well, and as the generations move forward they will pick up and do things, or not do things, depending on, you know, and people are more aware. They know their rights, they've got the internet now that they didn't have before, they've travelled more, they've seen the bigger picture, bigger than when I started my nursing, you were just sitting there and it was you and the sister and that was it.' (Interview 7)

Having explored the wider organisational culture with regard to the management of incidents and the apportioning of blame it was appropriate to explore the cultural issues relating specifically to nursing within the context of blame.

The Issue of Nursing and Blame

This was explored in a lot of detail as in many ways this was the main part of the research question. All of the subjects who were interviewed recognised a particular approach, which seemed to be peculiar to nurses and nursing. It was very much felt that ‘nurses were very hard on other nurses’. On exploring this further a number of different explanations were offered. These included:-

1. It is a way in which standards are recognised and maintained.
2. It is part of your development as a nurse.
3. It is how a profession behaves, it is what is or should be expected.

One manager commented

‘I think we have always been hierarchical and keen to manage our own profession but I think we maybe have done it with an iron rod.’ (Interview 9)

It was also reflected that there remains a group of nurses in practice who were trained in a particular way – through the apprenticeship system where hierarchical structures were a very strong feature and there was a regimented approach to both the care of patients and the management of nurses. Individuals were able to identify this with very specific people who were in managerial posts currently or that they had come across in their professional practice. One manager accepted that this was part of the culture in which they had trained but had tried to move away from this approach and when presented with a view which had been expressed in a previous interview that ‘nurses who have managed through the old school of nursing were more likely to look for blame and discipline than a younger generation’ responded

‘I would agree with that entirely, absolutely 100%. And I am one of the older ones. I try not to do that, I try to look for a more open approach to things and look for solutions as opposed to looking for blame. It’s easy to blame somebody... the difficult part is to say here’s the solution. I don’t think the younger generation are prepared to accept the blame now.’ (Interview 7)

One of the interviewees who had been involved in an incident was very clear about the reasons for this

‘Nurses have always been hard on nurses. I suppose it goes back to the days of the bossy matron and we all remember what they were like. Well if you are old enough you can. But even more recently there have been some real bitches of nursing officers who thought it was part of their job to make life miserable for nurses in whatever way they could. ...During my training you did not even speak to staff nurses and sisters never mind nursing officers. You were trained to respect more senior staff and what they say goes. So when you become qualified you do the same and you always knew that if you made a mistake you were in big trouble. You ended up in the admin office for a rollicking. That usually made you even more scared and even more nervous about doing anything in case you got it wrong.’ (Interview 14)

Staff representatives have seen a move away from the punitive approach taken by nurses in the past. Asked whether they felt that nurses have received unmerited punishments one response given was

‘I think in the past. If I were to go back 5 years I would say yes. But not recently. I think there has been a move because of clinical incident and risk management that the investigative meeting is more lenient - lenient is not the word but it is the only word I can describe – people are more empathetic to what has happened.’ (Interview 3)

There is recognition that on the whole nurses are deeply affected by an error and the potential harm it may have caused patients. It was reported by both managers and nurses involved that when a nurse is involved in an error they feel very guilty about what has happened. One manager reported that an individual nurse who had been involved in an incident was not at all concerned that her registration may have been at risk but only that no harm had come to her patient. One manager reflected that the staff who were involved in an incident

‘...were absolutely devastated, they were shocked that it had happened. ...they weren’t getting an awful lot of feedback from anybody else so I think they felt isolated in that situation that nobody else went to speak to them or tell them what the process was going to be. So the feedback they were getting was almost one of ‘well we’re being blamed for this’.’ (Interview 4)

Summary of Nursing and Blame

The perception amongst the interviewees was that nurses were more likely to seek to blame another nurse when something went wrong. They offered a number of potential reasons for this which reflected some of the literature. Almost inevitably this drew comparisons between how doctors and nurses manage clinical incidents. All those included in the study commented on the differences between the two different groups and consensus of opinion was that there was a balance to be achieved between the perception of the very hard line seen to be taken by nurses and that of a laissez faire approach taken by medical staff. The reasons for this are complex and related once again not only to approaches taken within each professional discipline but also the relationship between doctors and nurses. For example the case of a doctor issuing an instruction to a nurse that she knows to be incorrect but is assured by the doctor that if anything goes wrong he will accept the responsibility is one which all the participants recognised. They expressed a hope that it was no longer a common occurrence but nonetheless it did happen. More worryingly, there were still nurses who accepted this approach and would undertake an instruction following this assurance. This was confirmed by a representative from a staff organisation who recollected that in the recent past they had represented a member of staff who found themselves in position of being “bullied” into doing something. The representative also commented that the problem really related to the nurse’s concern for the patient on the one hand and on the other, a junior doctor’s perceived authority and power to insist that something is done.

‘...But the patient may be in a lot of pain or nauseous and the view is “I’m too busy, just do it and I will write it up when I come.” The nurse is caught in no-man’s land with a patient suffering...’ (Interview 3)

In describing an incident, which involved a relatively inexperienced staff nurse and a junior doctor, one interviewee described the perception of a hierarchical relationship between the two individuals

‘However, rank was pulled, well we felt, that was our perception,... well he was tired. This nurse went through all this investigation and there was a consequence at the end of it, where there appeared to be no consequence for the junior doctor, well, I don’t know whether there was a consequence because we don’t get to find out and I think that’s maybe the difference.’ (Interview 6)

The perception of the outcome is

‘They are treated very differently they get a wee word in their ear and that is it.’ (Interview 9)

Some respondents did acknowledge that they would not necessarily know what the process and outcome would be if a doctor was involved in a clinical incident but that there was a very clear perception that a ‘slapped wrist’ was the norm.

‘...there appeared to be no consequence for the junior doctor, well, I don’t know whether there was a consequence, we didn’t get to find out, and I think that’s maybe the difference. You never quite get to the bottom of it or get an end result. From a nursing point of view the processes are you start there and you finish here and everybody knows about it they shouldn’t but they do. But with a medical incident you start here... and you don’t hear anything about it...there doesn’t appear to be a conclusion...but not everybody who is involved gets to know the conclusion that happened to other people.’ (Interview 10)

It was also clear that previous experience, either directly or indirectly, of the way in which errors were managed coloured the approach adopted at a later stage. One interviewee described an incident that occurred prior to their nurse training a number of years previously and the effect that had on her. In this case the incident demonstrated to the individual how she would not approach such an issue once she had qualified.

'It was a list for Ts and As or something, and the staff nurse gave me the breakfast to give to this young child which I did and, of course, the child was for the operation that day and, of course, she came to me and said just tell them, don't tell them I gave you the breakfast to give, just say you done it yourself, and I was very young, she was, to me, the top of the tree, so I did it and I took all the flack that came with it, and she never ever even came back and said thank you very much for doing that. Again, it's about lessons isn't it, that was a valuable lesson that I learnt as a very young person, here you've got to take, and her response was well you'll not get the sack because I hadn't actually started my training. But it was a valuable lesson, and obviously stuck with me because I've remembered after all this time. I haven't come across that in my experience with people.' (Interview 7)

In a different set of circumstances and within a different training style one interviewee recounted an experience of a drug error as a student nurse

'I also remember as a student when a staff nurse gave the patient the wrong drug and she was so terrified that she swore me to secrecy by telling me that I would be blamed for the mistake as well. It was only a vitamin so I did not think it would be too bad. But when I think back on that it was really terrible. Actually what the really terrible thing is that I know a lot of my friends who I trained with were in the same boat.' (Interview 8)

Having identified the issues of blame and how it is apportioned both within nursing as a distinct discipline as well as within a wider organisational context, it is important to explore what type of culture should be adopted in order to improve the management of clinical incidents. The literature contains extensive references to a 'blame free' culture however there was little in the way of demonstration as to what a blame free culture would look and feel like.

A Blame Free Culture

The issue of blame having been raised by the interviewees, the researcher then introduced the concept of a blame free culture, an issue that has been discussed widely within the professional and lay press. The term 'blame free' has been used without a clear understanding as to what is meant by the term. It appears to be used as an expression to convey a culture in which individuals feel that they can openly report clinical incidents

without fear of reprisals. It is debateable as to whether what is actually meant is a culture in which there is no blame, as this does not recognise that there are situations for which individuals should be blamed for their actions or inactions. There is no sense that this is what some commentators expect to see and there is no indication that this is a culture which patients and their carers would accept. In particular there were a number of issues in relation to this concept, which merited further exploration.

1. Did individuals recognise the culture there were currently in as being one of blame free?
2. What did the concept actually mean to them?
3. Was it even a desirable outcome?

It was generally accepted by the nursing staff interviewed that they did not function within a blame free environment. It was also argued by some that this was not desirable. There was a recognition that a more appropriate environment was a just and fair system. One interviewee who throughout the interview had been very critical of the systems and general approach to the management of incidents felt that there were times that it was appropriate to blame nurses for something for which they were culpable but that this should not be the norm and that nurses were not offered the same 'protection' within the organisation as would be afforded to them in a court of law.

'If you have done something which is really bad and done it deliberately then you need to be punished. You know if you have done something wrong and the patient dies or is seriously ill then that is different, but not for every little mishap. Nurses are just pursued for every little mistake and that makes it worse... but when you have committed a crime then you are innocent until the police and the courts can prove that you are guilty. With nurses it works the other way round. You are guilty until you can prove that you are innocent.' (Interview 5)

Another interviewee argued that the acceptance of blame when something went wrong was very much embedded in an individual as part of their own personal development and could be attributable to childhood experiences of what happened when something has gone wrong.

‘I think it goes back to our childhood, you’re going to get the blame for that, you’re going to have to take the consequences and I think the consequences they perceive could be very great, it’s the stigma, they’ve got this on the record, or they’re in the office again, it’s that sort of stigma attached to it.’ (Interview 7)

As was demonstrated within the data looking at specific incidents there were attempts to try and attribute the cause of an error away from the individual directly involved (see incident 10 in chapter VI). This may be seen as a very child-like reaction to being found out in that there is a tendency to deny a wrongdoing even if the evidence is irrefutable. At the other extreme however there is some evidence where nurses accept that something has gone wrong and that they must be to blame and simply accept this as inevitable. The attribution of blame (away or towards self) is well recognised and recorded in social psychology literature.

When asked what a blame free culture meant to one manager the reply was

‘I do not honestly believe that there is such a thing because if someone is being negligent then they should be blamed for it. I think that you can try for an open one which be just and should be fair but I don’t think you will every get a blame free because quite frankly if your conduct is something which is not in keeping with your profession well they should be blamed and they should be dealt with. So I think it is probably unrealistic.’ (Interview 6)

‘Yes (name) very much talks about a kind of just culture, that’s not a no-blame culture, because I do not agree with a no blame culture but I do think a just culture is the way forward. I think people are getting better at talking about a just culture, but I do think it needs to be led from the top and now that we have a risk manger in post ... but you’re talking about a fundamental cultural change and that won’t happen overnight.’ (Interview 9)

Is a Blame Free Culture a Desirable Outcome?

There was general agreement that a blame free culture is not a reality nor is it a desirable goal. The term ‘blame free’ implies that no matter the circumstance no one will be blamed. The nurses involved in the study did not see this as a reasonable or acceptable

professional stance. They recognised that there are circumstances in which individual professionals need to be held to account for their actions but it is the way in which this exercise is conducted which will influence the overall culture. It is also clear that the calls for a blame free culture are in part an attempt to address the issue of sanctions applied to nurses and other healthcare professionals. If the first reaction to an incident is to blame and punish then seek explanations, individual practitioners will continue to be reluctant to discuss these issues openly. Blame will remain the dominant feature of the organisational culture.

Process of Managing an Incident

The processes involved in managing a clinical incident involved the formal recording of the incident, provision of additional information, formal reporting to a more senior individual, an investigative process and a final outcome. Those nurses who were interviewed described this process broadly however; there were invariably differences in emphasis according to the type of incident. Most made it clear that the primary aim of nurses involved in an incident was to ensure that the patient was safe and that all appropriate steps had been taken to ensure that any harm or potential harm to the patient was dealt with promptly.

The Formal Recording of Incidents

As described earlier this is done through a system of recording the main details around the incident and information concerning the patient and member(s) of staff involved. In exploring whether there were any significant barriers to reporting incidents a number of comments were made by the respondents. For example the pro forma used was seen as having some limitations with one manager commenting

‘The incident form is a bit of a disaster really. It tries to get so much information crammed into one form that it reduces some details to nothing more than a tick box and the boxes that are there to add in the details are too small. Almost always you end up having to get the staff to write a statement it’s the only way to get all the information you need to undertake the investigation.’ (Interview 12)

One of the nurses involved in an incident described how she felt that some managers appeared to be more interested in making sure that the paperwork was completed and showed little regard for either the patient or the member of staff. This she felt did nothing but heighten her already anxious state about what had happened.

‘I completed the incident form as you were supposed to and I was also asked to write out a statement of what happened. Some of the information was the same as had been provided on the form and so it was duplicated and a waste of time. I was also concerned that I could have been writing something down that they would use against me later on. It really is quite hard to know what to say and what not to say. So I stuck to the facts.’ (Interview 13)

It was recognised within the literature that poor reporting mechanisms and processes designed to deal with incidents could themselves be barriers to staff reporting incidents. The researcher was keen to explore whether there was any evidence that staff were deliberately not reporting incidents and the reasons why. This prompted a very mixed response from the interviewees.

‘...well that’s not my perception. I think that people are certainly much better at being open, I think it is a cultural change, I think we’re not there yet, I think getting there and I think some of us are getting there sooner than others. But no my experience is that people are not lifting up the carpet and sweeping things under it. From my own experience a doctor made a comment about ‘well, we’ll just forget that’ and it wasn’t allowed to happen so it is reassuring that whilst somebody tries to sweep things under the carpet, it wasn’t allowed to happen.’ (Interview 3)

‘I think it is very difficult for people to report their errors, however, it is worse if they don’t report them and they are found out later. Then it begins to look as if they are trying to cover something up...I suppose I can understand somebody who thinks well no-one’s come to any harm and there’s nothing else anyone can do anyway so I won’t bother. That way I won’t get into trouble, everybody won’t know about it and then we’re back to ‘is this going to be on my file will I lose my job’ etc etc.’ (Interview 14)

‘I still think that nurses will try and hide things rather than admit to making a mistake. Well who could blame them – they know they are

going to be blamed and that they will be disciplined and that will stay on your file. They are supposed to remove it after six months or something but I don't think they do. I think it is on your file forever and that they can use it in references and everything. You cannot expect me to believe that this is just forgotten about after six months – you have to be kidding. So to answer your question I would not be surprised if nurses tried to hide mistakes rather than own up.' (Interview 5)

A copy of the pro forma was maintained within a folder and kept at ward level. This was by necessity freely available to all staff to record incidents and as such the details of previous incidents were accessible. This lack of confidentiality was a concern raised by one manager during an interview and suggested that the process be adapted to ensure the nurse's confidence is maintained.

'As you know at the minute if you made – even if it is an alleged drug error, that would come in on an incident form and I have concerns that the members of staff will always get their names put in there with an alleged drug error and where is the confidentiality? What we have advised the charge nurses is that if that issue arises then they should take their copy out and lock it away because it is not fair to the staff either to have that in open display.' (Interview 6)

THE PROCESS OF INVESTIGATION

Whilst the policy relating to clinical incidents is very clear about the procedures required to undertake an investigation there was a significant degree of variability in how these were approached by each manager. This appeared to reflect the managers' experience and background as well as the nature of the incident itself. This led to a perceived inconsistency in the approach adopted and it not being clear which approach would be adopted in a given set of circumstances. This was evident both between and within managerial groups. For example, in some cases drug errors were managed using a formal investigation process and some were managed using a process of reflection. An explanation offered related to the need to be flexible in relation to the severity of the incident i.e. the more severe the incident the more likely that the process would be a formal investigation. For what were regarded as 'minor errors' the process was more likely to follow a reflective process. One manager described their use of the policies as

‘I think they are useful as guidance as to what should be done but I do not see them as prescriptive (sic), because a lot of it is to do with the individual incident and the individual concerned and what has happened but it is useful to have a policy so that an investigation has a structure but I think it is important to look at things individually. One drug error is not the same as another, I think you also have to be as prescriptive as you must look at it as an individual incident and it is not just a repetition of what has been done before and we do not just repeat what happened before we must look at it in depth.’ (Interview 10)

This flexibility however resulted in a sensitivity of there being a set of rules for one and a different set for another. This was noted by all groups as being a problem. The outcome being that if a nurse was involved in an incident the process and outcome varied according to a number of factors

- The perceived severity of the incident
- The impact of the incident on the patient
- The managerial unit within which the incident took place
- The manager who was on duty at the time
- The manager involved in the investigation
- The area in which you worked
- The union representing the individual nurse
- The representative from the union

This flexible approach was achieved at the expense of a perception that there were times when it was seen as unfair. There was a growing perception, for example, that the processes involving reflection was a ‘soft option’ and that the investigative process was more punitive. Managers were keen to point out that it was not regarded by them as a soft option and corroborated this view by referencing the views of staff who had undergone the process (this involved a piece of written material that was submitted by the member of staff to the manager outlining the incident, their role, an understanding of the actual and potential consequences of their actions or inactions and a demonstration of understanding of what had gone wrong).

There appeared also to be a lack of consistency in how this process may be used on its own or alongside the formal investigative process. Some reported that this was used as a stand-alone process and others that this was used as well as the formal investigation. The flexibility also introduced variability in terms of deciding the severity of the incident. This was in particular related to drug errors. For example, some quoted that any errors involving a controlled drug were automatically a formal investigation rather than a reflective approach. It was apparent throughout the interviews that there were a number of areas clearly seen by all as being more serious than others. Medication errors involving controlled drugs were regarded as one such area. In exploring this issue a little further it was noted that this was for two main reasons.

The first relates to the impact or potential impact (in the case of a near miss) of a patient receiving either the wrong controlled drug or the wrong dose. This was regarded as greater than the patient being given the wrong vitamin or paracetamol (the two most often quoted examples). Yet there seemed to be no recognition that a number of drugs could have equally devastating effects on the patients but are not classified as controlled under the terms of the Controlled Drugs Act.

The second related to the legal implications of something going wrong in relation to controlled drugs. They were viewed as being different from non-controlled drugs because of their legal status. This relates more to the safe storage and handling of the drugs within the ward area as opposed to the role they play in the patient's clinical management.

In a small number of cases the formal investigation took the form of a system review where the managers, staff and their representatives formally reviewed the systems, policies and processes involved in the incidents. As the research period was coming to an end the new processes involving root cause analysis were beginning to have an impact and it was evident that this format would be utilised increasingly. However, prior to the introduction of the new policy this system was adopted in two major incidents. In these cases the main stakeholders physically walked through the processes and procedures involved in the incident in order to gain an understanding of the environment, the

intricacies of the clinical processes and interactions of staff groups (both clinical and non-clinical), the potential distractions and to examine the 'hand offs' between one part of the process and another which might have contributed to the incident.

This process was commented by both managers and staff as being a very helpful one and was regarded as being less threatening to the individuals involved. It also demonstrated where changes could be made to 'live' systems of work and processes as opposed to an abstract understanding of what should happen in theory and what actually happened in practice. The reports produced from this exercise were more detailed and more specific in recommendations for change. There was a clear action plan that resulted in those involved being able to identify where the problem lay and to contribute to the process of rectifying any deficiencies.

The investigative process was not surprisingly recognised as being a stressful situation for all involved but in particular to the member of staff under investigation. It was commented by a number of interviewees that even the language associated with the process has a legal basis for example 'investigation', 'hearing', 'witnesses' 'representation' 'mitigation' and 'statements'. One nurse who had been subjected to the process drew a number of parallels from the legal processes.

'For example no matter what happens, no matter how trivial the incident is, we are subjected to an investigative hearing that makes you feel like a criminal. Just look at the way you have to ask witnesses to come along to be questioned by managers and your union rep. It's like being in court only it's a manager that is your judge and jury. You cannot call that fair. They have the power to sack you on a whim.' (Interview 13)

Later, the interviewee drew further analogies from the legal processes by stating

'It's just like the courts. You try and make the punishment fit the crime.'

And

‘...when you have committed a crime then you are innocent until the police and the courts can prove that you are guilty. With nurses it is the other way round. You are guilty until you can prove that you are innocent.’ (Interview 13)

Within Chapter IV a description of the situation as outlined by the Royal College of Nursing was offered in relation to some of the issues its ongoing research had concluded, in particular the practice of suspending nurses at the outset of an incident. Throughout this research there was no indication that this was a practice within the subject organisation. One manager described how they felt that a nurse should have been suspended as the individual was potentially a danger to patients and was at risk of committing a similar error. However, an alternative course of action was undertaken preventing the need for suspension and the associated trauma. It is clear that the experiences and practice within this organisation are significantly different from those described by the RCN.

‘As far as I am concerned at that point I should have been phoned at home because this person should have been suspended until we knew what was going on. This person has no recollection as to why she has not signed for drugs, there is also the issue of ‘is she actually just forgetting to sign for them? Has she actually given them and has she actually given the right things.’ So I think there was a huge issue surrounding this. ...

I then telephone the charge nurse to find out and ask when the nurse is back on – ‘Oh she is off sick. When is she meant to be on – the weekend, we cannot have her back here. I am not having her on duty giving out drugs until we know what is going on with her.’ We have got to think of patient safety and her own registration. If we are at the stage that this registered nurse cannot give drugs then we must suspend her so that I know what is wrong. In the meantime I am going to refer her to occupational health – I am going to make a management referral but she self referred in the interim.’ (Interview 6)

Clearly from this incident the issue of suspension was regarded as the best option of ensuring safety not only for the patients but also for the individual registered nurse. As suggested by the RCN in their submission to the CMO an alternative strategy was found to ensure the safety of patients to provide the necessary support for the nurse and to establish the root cause. In this incident the nurse was found to have a medical condition

that was appropriately managed and there were no further problems relating to her ability to practice.

One subject who had some experience of being both an investigator and subject of an investigation commented that

‘I felt that it was a bit hostile, it was almost looking for blame and I thought we were going down this route of “we have a problem how can we resolve it and make it not happen again” as opposed to looking for blame.’ (Interview 7)

THE OUTCOMES

Having undertaken one of the processes there were a limited number of potential outcomes for the member of staff involved and for the organisation.

- No action against the individual member of staff
- The member of staff undertook a reflective exercise
- The member of staff undertook a period of additional education
- The member of staff was disciplined to an appropriate level
- There were changes to the systems within the organisation
- Formal action plan was agreed

The major theme in relation to outcomes was similar to process in that there was a perceived lack of consistency within and between managerial units. Some reported that every incident, no matter what the cause or outcome, would result in some form of additional education and training for the member of staff. This was not universally applied. As noted earlier within the review of the documentation, where there had been an agreement for further training or supervised practice, there was evidence that this has not been formally evaluated in all cases. The managers who were interviewed were clear that this was followed up by the ward charge nurses and they would ensure formal ‘sign off’ to the process. One described how a member of staff she was dealing with insisted

that the charge nurse had formally reviewed her. She required the reassurance that she was fit to practice and would not be a danger to her patients.

‘The policies are there to ensure consistency, but I think where you do have individuals, there is an opportunity for inconsistency which does make it very unfair and you can understand the people who feel slightly bitter over perhaps an incident that they’re being reviewed or investigated against, if they know that somebody else has made the same mistake and their experiences were quite different. So I think it is difficult.’ (Interview 3)

The level of disciplinary action was also viewed as being inconsistent. There were significant issues surrounding the expectation of the member of staff, their representative, the manager involved and their manager. The member of staff appeared to expect to have some form of disciplinary action taken against them. Their expectation was based on previous experiences – either themselves or other individual cases they were aware of. This also coloured their view as to whether they felt that they were dealt with fairly or consistently with previous cases. One nurse comments

‘I have a friend who used to work in this Trust but doesn’t work here anymore, who was involved in a drug error and she seemed to have a much harder time than I did. She had to go to more than one meeting and she did get a disciplinary warning and was told that if the same thing happened again she could find herself sacked. She really felt as if she was being blamed for something that happened that really wasn’t her fault because she gave the patient a wrong dose of drug, but she had given the dose that was prescribed by the doctor. The doctor had prescribed the wrong dose. She ended up in a lot of trouble and absolutely nothing happened to the doctor, well ,at least nothing appeared to happen to the doctor.’ (Interview 13)

It was reported that the manager and the staff representative would have an informal discussion about the likely outcome based on the facts of the case in advance of any formal investigation recognising that this could change in light of additional information being presented at the formal hearing. It was also reported that managers had some evidence to suggest that staff representatives were preparing their member to receive a more severe penalty than was being suggested in order that when a lesser penalty was

given the staff representative was seen to have influenced the decision down the way. This was a detail which was presented in the research after discussion with trade union representatives and therefore was not commented on by them. Managers also perceived that they were being scrutinised by their line managers in relation to the outcomes of processes. One commented

‘I have been involved in a number of disciplinary hearings and almost without fail my manager indicated that if they had been involved they would have delivered a more severe punishment. So for example if I gave a member of staff an oral warning, my manager would say that they would have given a written warning or even a first and final warning. But as I pointed out on several occasions they were not in possession of all of the facts and that they could not determine an outcome based on a few details. Which to be fair to them they accepted but it does illustrate the point that senior nurses expect staff to be disciplined and they are even prepared to suggest the level without the facts.’ (Interview 11)

Additional Education and Training

Providing additional education and training was viewed as being an essential outcome that was usually in conjunction with some other outcome for example disciplinary action or reflection. This required the involvement of other members of staff and raised some concerns over maintaining the confidence of the member of staff. This could be the ward charge nurse or a member of staff from the practice development department. This typically took the form of some supervised practice to ensure that the individual’s practice conformed to the organisation’s policies and procedures. This outcome was recognised as requiring an investment of time and effort from the individual member of staff as well as other individuals from the organisation. One of the main problems associated with this format was that it became a more visible and public outcome. For example, it would not be routine for a long standing qualified member of staff to have to undertake a specific procedure under the supervision of either the ward charge nurse or practice development nurse. Thus the incident and its consequences for the individual member of staff becomes evident to the wider team.

System Changes

Throughout the interviews it was clear that there has been very little change made to systems and processes. There was some evidence that this had taken place in only a small number of incidents. It was interesting to note that even where there were a number of similar incidents in the same area or across different parts of the organisation these had not been more formally reviewed with regard to the process or system. For example, one manager observed that there had been a 'glut' of drug errors within a ward area over a very short period of time. When this was discussed with another manager from a separate part of the organisation they reported a similar problem in another ward. Despite this there was no review of whether the errors were occurring as a result of a latent fault within the system – more the assumption that these related to individuals and that it was nothing more than a coincidence that a number of similar incidents had occurred within two different areas across the organisation.

The system reviews described earlier were examples of what could be achieved where the investigation concentrates on systems of working rather than simply investigating the role an individual played within a particular incident. There was little evidence to suggest that these were shared more widely than those individuals who were directly involved in the incidents and a few other senior managers within the organisation. It was therefore a missed opportunity to demonstrate how a different approach to the management of an untoward incident could lead to a more productive outcome for the individuals involved and the wider organisation. One of the managers interviewed was asked 'Do you tend to find that investigations concentrate on individuals rather than a system of working or a process?' responded

'I try and make it process, the systems because it's usually the systems which are at fault. People will follow the process or follow the systems that you have in place so I think it's about looking for changing the processes and changing the systems. You will as we spoke about earlier, have individuals who no matter how much you train them or no matter what you do with them they will still do it wrong and something has to be done about that, but then again you could still say is that the system you have in place that's not picking these people up or is the organisation as a whole not looking at it's systems properly and saying well take for

example sickness absence if you like rather than an individual?’ (Interview 7)

Wider Learning

The issues of wider learning were discussed extensively during the interviews and the major barrier to sharing information appeared to be the need to maintain the confidential nature of the incident and the investigation. In one of the managerial units there was a process whereby certain clinical incidents were discussed as part of a forum where the charge nurses met on a regular basis. It was reported that it became apparent that those present were aware of the situation because they had discussed it informally among themselves. This process allowed individuals to share what had happened and how it had been resolved. The manager involved in this process reported that this developed into a ‘double-edged sword’. In a positive way the charge nurses were able to support each other. However, it also illustrated a problem in that if a particular incident was being described by a charge nurse, and another may comment ‘yes that happened in my ward’ and that had not been reported or dealt with.

The managers recognised that there was very little learning of lessons from the incidents within the managerial units but that there was even less learning across the organisation. Once again the reasons for this were explored and the ability to undertake such a process whilst at the same time maintain an acceptable level of confidentiality was seen as challenging. It was however at the same time acknowledged by managers that the hospital grapevine had already ensured that the incident was widely known and commented upon. There seemed to be little acceptance that it was possible to present the cases anonymously to allow the organisation to share the lessons which should be learned in order to prevent a similar incident occurring in a different part of the organisation. This was an issue which was beginning to change with the development of the root cause analysis process that was managed by a disinterested member of the wider management team. This allowed an objective presentation of the information relating to the incident and the changes required to prevent its recurrence. A manager included in the interviews observed that lessons were not being shared and suggested a potential method of ensuring

anonymity and reducing the tendency for individuals feeling that were being blamed. When asked specifically how lessons were learned, replied,

‘Word of mouth. Well you could ask the question and you try to be as confidential as you possibly can, but word. these things do tend to have a habit of getting out, and through whatever fault, now that could be the nurse themselves telling people, not the fact that the managers are telling. I don’t think, in relation to drug errors, I don’t think there is enough feedback. Now individuals don’t need to be named, but there could be some feedback, the fact that, this incident happened, and this is what we did about it. Because often the person who’s made that mistake feels that they’re very isolated and that they’re the only people that have made this mistake, and I think if we can share, widely, what’s happened without mentioning the individual’s name, and what we’ve learned about it, I think people would be happier. Then we would be coming to a culture that if this happens every 3 months, then there’s feedback of incidents, people then wouldn’t feel that they’re being blamed and sought out, as an individual.’ (Interview 11)

The apparent lack of ability for the organisation to learn lessons from incidents either within or between its own managerial units, resulted in there being little opportunity to review incidents which were reported at a wider regional or national level. These tended to be restricted to the formal notification processes that facilitated the distribution of information relating to known hazards, usually related to specific pieces of technical equipment rather than processes.

It was recognised by one of the interviewees that the organisation was not good at sharing information – whether that was good or bad experiences.

‘What I would say is that we are not good at sharing. We’re not good at sharing the good practices or the bad practices and we’re not good at sharing outcomes. It’s like that’s dealt with that’s fine and it maybe raises its head maybe a couple of years down the line when a similar incident happens and you think – well I remember that, what happened with that?’ (Interview 12)

Chapter VIII

FATAL ACCIDENT INQUIRIES

BACKGROUND

The final phase of the data gathering process consisted of a review of determinations from fatal accident inquiries (FAIs). There are a number of reasons for examining this data. These are:-

- To examine a process designed to establish the facts surrounding a clinical incident as opposed to one designed to establish fault or apportion blame.
- To examine a process which comments on the impact of systems of working in relation to the outcome of a fatal clinical incident.
- To review the final determinations in relation to nursing practice and to examine how nursing care was examined through this process.
- To determine whether the processes adopted within fatal accident inquiries are transferable to healthcare organisations in order to improve their investigative processes in clinical incident management.
- To outline any recommendations for improving the current fatal accident inquiry system.

As explored within the review of the literature this form of inquiry is the Scottish equivalent of the coroner's court within England and Wales but there are some important differences and these were described within chapter III. The main purpose of the inquiry is one of fact-finding and it is not intended to find fault. Given the nature of the requirements of the determinations of fatal accident inquiries it is arguably difficult not to be seen to be identifying fault, either at an organisational or personal level. However, a key principle is that such inquiries are established in order to determine facts and not culpability. Sheriff E J Bowen reiterates this in the determination following an inquiry and he notes

“Lord President pointed out in *Black v Scott Lithgow Ltd* 1990 SLT612 the sheriff is given no power by section 6 of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 to make a finding as to fault.” ...“For that reason and others a Fatal Accident Inquiry is not the appropriate forum for consideration of issues of fault of the type that might provide the basis for an action for damages.”

Whilst Lord President Hope’s outline is a well-accepted principle, the determinations used within this chapter show that facts which are established during an inquiry may be used later, whilst recognising the actual determination may not be admissible in a future judicial process. The main reason being the determination is expected to identify whether any failures in the system of work contributed to or could have prevented the death. Sheriff Bowen does suggest that

‘The court is entitled to examine much wider issues, including areas of practice generally, and is entitled to direct criticism in such terms as seem appropriate if satisfied upon examination of the facts that it is right to do so.’

Under Section 6 (1) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976, the sheriff is expected to determine 5 different aspects of the circumstances surrounding the death. These are

- a) Where and when the death and any accident resulting in the death took place.
- b) The cause or causes of such death and any accident resulting in the death.
- c) The reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided.
- d) The defects, if any, in any systems of working, which contributed to the death or any accident resulting in the death.
- e) Any other facts that is relevant to the circumstances of the death.

SOURCE, NATURE AND FORMAT OF DATA

The source of the data for this phase was those determinations lodged on the Internet web site for Scottish Courts (www.scotcourts.gov.uk). The dates for the opinions range from

5th March 1999 to 21st January 2004. Prior to undertaking this part of the data collection, it was established whether the subject organisation had been the subject of recent inquiries or whether there were any pending. This was not the case. The organisation had been the subject of FAIs but they preceded the timeframe within which the examination of clinical incidents was undertaken. Similarly, there were no impending inquiries. The ability to examine an organisation’s management and outcome of an incident alongside the process and outcome of a FAI would have added a further interesting dimension to the study.

A total of 41 determinations were reviewed. These are listed in full within the bibliography. A breakdown of the places of death is presented below in table 11. The final determinations are open documents and are available to the general public. For this reasons they have not been anonymised within this analysis.

Table 11 : Place of Death Noted Within Fatal Accident Inquiries.

Place	Number
Hospital	31
Home	3
Prison	3
Place of work	2
Police Custody	1
Aircraft accident	1
Total	41

Many of the inquiries did not yield any data relevant to this study and therefore a selection has been used in order to illustrate issues germane to the study. As a result these are in the main those fatalities that occurred in hospital.

Gordon Scott Niven

This 16-year old male was admitted to hospital following a fall from his bicycle. His behaviour in the accident and emergency department was aggressive and inappropriate. The consultant requested (authorised) his removal by police officers to a local police station. His condition was noted to have deteriorated and following examination by the police surgeon he was returned to hospital where he was found to have a skull fracture

and raised intra cranial pressure. He was referred and admitted to the local neurosurgical unit. He later died. Under section 6(1) d the Sheriff determined

“That the said accident and subsequent death were not caused by or contributed to by any defect in a system of working.”

The sheriff does criticise the decision to have the patient arrested and taken to the police station, a decision the Sheriff feels was both wrong and insensitive given the circumstances. The sheriff then goes on to say

“I express no view of the matter of whether the decision was one that no reasonably competent medical practitioner would make in the exercise of ordinary care.”

The sheriff makes this point as it had been submitted to him that he could not level “any criticism at any doctor unless it was shown that his conduct could not be so regarded.” The sheriff recognising that the submission was based on *Hunter v Hanley* rejected the submission on the basis that the court has no power to find fault (and refers to the Lord President’s determination in *Black V Scott Lithgow Ltd*) but illustrates the court’s entitlement to comment on wider issues. For example, the cause of death was recorded as a head injury as a result of falling from a bicycle and the sheriff hypothesises that the death could potentially have been avoided if he had worn a protective helmet, and before turning to the main points relating to how Gordon was cared for, comments;

‘In the first place I have made a finding that the use of a protective helmet might have avoided this death. I make that finding – and indeed do so at the forefront of my findings – in the knowledge that the use of such a helmet does not necessarily eliminate the possibility of serious head injury in severe bicycle accidents and indeed might not have done so in this case. I also acknowledge that Gordon’s parents may well have done all that they reasonably could to persuade him to wear a helmet but met with the usual resistance, which people of all ages put forward to being encumbered in this manner. This case however demonstrates just how easily a cyclist may sustain a fatal head injury. Gordon was not on a public road. He was probably not travelling at great speed. No motor vehicle was involved. He was simply playing as boys do on a makeshift ramp when a sudden stop propelled him over the handlebars onto hard ground. If the widespread

publicity that this case has attracted highlights that danger as much as the more sensational aspects the inquiry will have been of value for that reason alone.'

This determination demonstrates a number of issues with regard to the value of FAIs. For example, it served as an objective view that the care received by Gordon was entirely appropriate, it attempted to redress some of the balance in relation to media coverage and at the same time raised the awareness of the need for cyclists to wear protective helmets.

Group of Intravenous Drug Users

During the period of April to August 2000 there were 18 intravenous drug users whose deaths later became subjects of individual fatal accident inquiries. The inquiries were presided over by the same sheriff who, rather than making the same point in each determination, referred to the outcome of the inquiry into the death of Andrea McQuilter.

In all the determinations the sheriff concluded 'that the death of the deceased was not caused by any defect in a system of work.' The media at the time raised the concern that a number of deaths among this group were perhaps a cause for concern in that local health and social systems were failing this group of the community. There was both implicit and explicit criticism of health services. In particular the perception that drug abusers did not receive the same level of clinical care afforded to non-drug abusers. Whilst the sheriff's determinations concluded that systems of work contributed to the deaths, the headlines at the time were seen as criticisms of health services within Glasgow. The Sheriff Principal makes reference to the 'perceptions' within his determination.

'During the course of the inquiry evidence repeatedly touched on the issue of "perceptions" of drug users, and indeed of those who support them, as to the quality of medical treatment available to drug addicts. This is an area of delicacy I approach with caution, not least because I am in no doubt that to attempt any wide ranging examination of standards of treatment of drug users goes beyond the scope of a fatal accident inquiry. It would be equally wrong to attempt to deal with the question of whether there is any justification for a perception that drug users are treated

contemptuously by medical and nursing staff. It is manifestly obvious that they are a difficult group to deal with and treat.'

Sheriff Principal Bowen, later in his determination, having explored some further issues around the perceptions of drug abusers and their access to health services particularly within the secondary care sector, goes on to conclude

'The above consideration lead me to the conclusion that the problem surrounding this issue of perception may to a significant extent be intractable. I am, however, satisfied that it is a problem which is recognised and being addressed.

In drawing his determination to a close the Sheriff makes only three recommendations. One relates to the need for wider publicity in relation to the dangers of contracting fatal infections as a result of injecting heroin. The second relates to the need to further research into the treatment of specific infections and the last deal with the distribution of written information to medical and nursing staff. As is evident only one of these relates to the management of the outbreak of infection amongst this group of patients, which resulted in so many deaths. This in part reflects an observation made earlier in the determination that the injecting of heroin is fraught with significant risks to the individuals health and well being and that death is not an uncommon outcome for those involved. The Sheriff Principal recognised that death was almost inevitable as a result of the abuse of heroin and the outbreak of a particular infection, that the health systems acted appropriately and that there was nothing more that could or should have been done that could have avoided the deaths under these circumstances.

Maureen Smyth.

In this case the patient attended the accident and emergency department at Monklands General Hospital. Following a diagnosis of acute gout and a query over septic arthritis and blood samples taken for analysis, Mrs Smyth left the hospital and stayed with a friend for 4 days until her condition improved. During these four days a number of attempts were made by the hospital to contact Mrs Smyth's GP service to inform the relevant practitioners of the blood results, which concluded that Mrs Smyth had a serious

infection. During the next 10 days there are a number of circumstances involving a number of different medical practitioners, the consequence of which being the appropriate action to treat the infection was delayed. Mrs Smyth died 13 days after her initial attendance at the accident and emergency department.

The Sheriff involved in the fatal accident inquiry into this death made a number of comments on various sections of the determination. Under section C of the act the sheriff is asked to determine whether there were any precautions, which could have prevented the death. In this case the sheriff identifies that there were reasonable precautions however he records that he

‘was not satisfied on the evidence that there was a real possibility that such precautions would have avoided the death.’

Under section D of the act the sheriff is asked to determine whether there were any defects in the systems of work. In this case the sheriff identifies 4.

1. There was a lack of any system, whether computerised or manual, at Medicare for recoding calls on patients, which would enable a Medicare doctor to know of any recent contact between other Medicare doctors and the patient in question.
2. The system of work in the Bruce Medical Centre with regard to laboratory results was also defective.
3. The system in the Bruce Medical Centre for dealing with Medicare slips was also defective.
4. The system in relation to the making of house calls to patients of the Bruce Medical Centre was also defective.

By way of completing his determination the sheriff stated

‘I acknowledge that some of these defects in working systems may well by now have been attended to and put right. However, to any extent that they have not been attended to, it seems to me that they ought to be as quickly as possible.’

This determination illustrates how the process of a FAI can be used to identify problems with systems of working. It offers the organisations involved an objective view of the issues to be addressed. Currently there is no formal system within the process to identify whether these issues have been addressed and the weaknesses rectified. Perhaps the only way this will be known is if another death is investigated and similar issues are raised once again. In order to address this apparent anomaly it is suggested that the system could be extended to require organisations responsible for the systems of work, which have been criticised, to follow these up and to submit a report within a given timescale. This would complete a process of having identified any defect, action is taken to rectify the problem. This process would be akin to the procedures adopted by the Health and Safety Executive, a body with the authority to issue an organisation with specific instructions to improve an unsafe system of working.

Hamish Adamson

This inquiry relates to a newborn boy whose death was certified on the day of his delivery. The baby's mother had been admitted to Creswell Hospital, Dumfriesshire in order that her labour may be induced. Having identified the cause of death, Sheriff Kenneth Ross identifies a number of defects in the system of working which contributed to Hamish's death. These were described as:

- a) failure at Cresswell to have a proper and clearly understood policy for the induction of labour by Prostaglandin gel in respect of:
 - 1. time of commencement
 - 2. monitoring of the foetus and mother during induction

- b) Failure at Cresswell to have a proper clearly understood policy on preparations for emergency caesarean section operations required in the course of labour in respect of:
 - 1. the circumstances in which the need for such emergency operations is categorised as immediate
 - 2. a realistic time for completion of such operations from the decision to operate until delivery

3. The need for one member of the operative team to assume responsibility for co-ordinating and monitoring such preparations
- c) failure to have sufficient midwifery staff on duty to cope adequately with the workload at Creswell on the 17th and 18th September (i.e. the day of induction of labour and birth of Hamish).

Any incident which results in a death is a major traumatic event for all those involved. When that death is of a child, or in this instance, a newborn baby, the resultant trauma is significantly intensified. Many people would have some sympathy with the parents of the child who would perhaps look for someone to blame for such an incident, and it is not difficult to imagine that the staff involved in the incident would find it difficult not to blame themselves for the outcome. This incident illustrates, perhaps more than any other, the need for such Inquiries set up under the 1976 Act, which allows an independent individual the opportunity to review all the circumstances surrounding the event and to take that opportunity to establish the facts and not faults, whilst at the same time identifying any defects in the system or reasonable precautions that might be taken, other relevant facts as well as making recommendations.

In his determination into the circumstances of Hamish Adamson's death the sheriff finds a number of other relevant facts. These were:

- a) the dedicated 3333 telephone line for use in emergencies is not always used by staff at Creswell when requesting the attendance of, for example, anaesthetic staff
- b) not all relevant records of telephone communications from and between hospitals of Dumfries & Galloway Acute Maternity Hospital Trust are retained
- c) The team system of midwifery care at Creswell did not ensure that Mrs Adamson received continuity of care during her stay in Creswell
- d) there are no clearly understood arrangements at Creswell for obtaining cover if midwifery staff are unexpectedly unable to attend for duty
- e) the procedures at Creswell for informing staff of changes to any guidelines or in the practice to be followed are informal and unsatisfactory

- f) The procedure for dealing with patients' concerns after or during treatment prevents further direct contact with the patient once it is known that legal advice is being sought by the patient
- g) The procedure for dealing with patients' concerns after or during treatment does not conclude with specific advice on how to access the formal hospital complaints procedure
- h) there was no proper or adequate inquiry by the Trust into all the circumstances of Hamish's death, nor any proper or adequate review of the circumstances which preceded his death
- i) there appears to be confusion about the meaning of (Guidelines on Induction of Labour) issued by the Royal College of Obstetricians & Gynaecologists in 1998

Having identified the defects in the system and the other relevant facts as viewed by the sheriff, he goes on to make 26 recommendations in order to improve systems of work and hopefully prevent a recurrence of another incident in the future.

William Sneddon, Lemond Mulroy, David Brodie MacFarlane, Agnes McCool, Archibald Haining,

This fatal accident inquiry was a little unusual in that it examined the deaths of five individuals in the same hospital and indeed during the investigation it was suggested that under the terms of the Act such an inquiry was inappropriate. The sheriff disagreed that the need for such an inquiry was inappropriate and outlined the reasons why. This explanation is outlined later. In his determination, the sheriff deals with each of the deaths in turn and makes a determination under each section of the 1976 Act. In relation to this particular piece of research, the main areas of interest are those around any systems defects, other facts relevant to the circumstances of the death and any recommendations. Therefore, the analysis relates directly to these areas.

1) *William Sneddon*

The sheriff determines that there were no defects in the systems of working and there were no other relevant facts around the circumstances of death and he makes no recommendations.

2) *Lemond Mulroy*

There were no defects in the system of working which contributed to the death. The Sheriff noted one relevant fact which was:

“Some aspects of Mr Mulroy’s nursing care while in Ward 7 were unsatisfactory and caused distress to him and his wife”.

It is probable that these were the result of a shortage of nursing staff on the ward and the Sheriff makes two recommendations in light of these findings.

3) *David Brodie MacFarlane*

The Sheriff determines that there were no defects in the system of working which contributed to this individual’s death and demonstrates two relevant facts surrounding the circumstances. These were:

“there was an unexplained delay in changing Mr MacFarlane’s analgesia to a syringe driver with Diamorphine after an ultrasound scan revealed the likely existence of metastatic lesions of his liver”.

“ Mr MacFarlane was fasted unnecessarily for several days after the ultrasound scan was carried out”.

As a result of this finding the Sheriff makes one recommendation.

4) *Agnes McCool*

The Sheriff determines that there were no defects in the system of working which contributed to this death and identifies one relevant fact to the circumstances, that is:

“The radiologist’s report on the x-ray taken on Mrs McCool’s admission to the Infirmary was not seen by the treating consultant before her transfer

to Kirkcudbright Cottage Hospital and the completion of the discharge by the treating Consultant”.

As a result of these findings the Sheriff makes two recommendations.

5) *Archibald Haining*

The Sheriff determines that there were no defects in the system of working and outlines two relevant facts:

“Pressure on the intensive care unit resulting from a staff shortage caused the closure of the High Dependency Unit where Mr Haining was a patient there”. As a result, he was transferred to one of the wards. He was re-admitted to the Intensive Care Unit the next day.

“While in the ward there was a lack of nursing attention to Mr Haining between about 12 noon and 14.00 hours, during which his condition deteriorated”.

As a result of these findings the Sheriff makes one recommendation.

In his determination Sheriff Ross spends a significant amount of time outlining the reasons for undertaking this inquiry, given the circumstances of each death within the same Institution, and concludes

“In the present inquiry there were in my opinion matters of serious public concern which justified the holding of an inquiry”.

and having identified some of the issues within each of the individual deaths, goes on to say

“all those who died were being or had been treated in the same hospital. Some of the information available to the Procurator Fiscal was suggestive of poor nursing standards in several of the cases. The issue of the appropriateness of transfers between wards arose in more than one case. I do not think it is reasonable to seek to criticise the crime for drawing all that together in the public interest”.

Clearly in his determination Sheriff Ross seeks to balance a view on the one hand, which is that the counsel for the Trust involved felt that it was inappropriate to hold such inquiries into these deaths, whilst the procurator fiscal felt that there were such issues being brought into the open that it was in the public interest to have the inquiry undertaken. The sheriff also notes that the circumstances around the deaths and the subsequent fatal accident inquiry innovated considerable interests from the media and as such he makes comment on this issue in his determination.

“This inquiry appeared to generate considerable media and public interest. Unfortunately media coverage perhaps because of constraints of space or time rarely gives a complete picture of all that is said at an inquiry of this length. For these reasons I have tried to set out the larger picture in greater detail. It is important to emphasise that none of the evidence established or even suggested that any of the deaths was caused by any act or omission of the medical or nursing staff at Dumfries & Galloway Royal Infirmary, nor was there any reasonable precautions whereby any of the deaths might have been avoided. The evidence identified defects in some systems of working and deficiencies in some of the nursing care, which was given, but this must be placed in context. One of the nursing witnesses referred to the thousands of patients who had passed through her ward since the events described in the evidence. While what happened in the cases I have described was in some instances unacceptable and upsetting, it does not justify any lack of trust in the doctors and nurses and other medical and auxiliary staff who work at Dumfries & Galloway Royal Infirmary. Indeed many of the witnesses were impressive examples of their profession and it is clear that they took a caring and responsible attitude to their work and to the patients under their charge. It is also clear however that they worked under considerable pressure of resources”.

The final comment by the Sheriff raises a number of issues of interest in this research. Primarily this relates to the way in which such incidents are portrayed within the media and the impact that has within the general public on the level of trust that the community can have in their local hospital and the doctors, nurses and other clinical staff who provide the care there. In this instance the Sheriff is making the point very clearly that it was right and proper for such an inquiry to take place to establish the facts surrounding each of the deaths, and that in this instance the general public in whose interests the inquiry was conducted, had no cause to have any loss of faith or trust in clinical staff within the hospital. At the same time however, he concludes that the organisation has a

number of issues, which require to be addressed within the systems of working which would improve the environment in which such clinical care is provided, whilst acknowledging that all staff within the health service are working under considerable resource pressures.

Imran Khan

The Fatal Accident Inquiry into the death of Imran Khan, a 15-year-old boy, who died at the Victoria Infirmary in Glasgow in 1998, was in some ways similar to the inquiry into the 5 deaths in Dumfries & Galloway Royal Infirmary. It also generated considerable comment in the press and media. In his determination the sheriff principal identifies that

“Imran Khan was 15 years of age at the time of his death. On the 13th February 1998, he was the subject of a vicious attack in the course of which he was stabbed repeatedly. While the stab wounds penetrated his chest wall, as the result of the help of a complete stranger at whose door he arrived, he was conveyed very swiftly to the Victoria Infirmary. He was found to have a collapsed lung which was treated by the insertion of a chest drain. Unfortunately he died 7 days later as a result of toxic shock syndrome. The purpose of this inquiry has been to examine the events between the time of his admission to hospital and his death on the 21 February 1998 to determine whether failures in care led or contributed to his death. It is no part of the function of the inquiry to examine the circumstances or background of the assault”.

In his determination the Sheriff Principal outlines the processes of care which Imran received during his stay. Given that the inquiry quite rightly did not deal with the circumstances surrounding the assault on Imran, it is perhaps not unsurprising that the fact that he was so brutally assaulted was sometimes lost in the media coverage and the unfortunate by-product was the intense critical comment on the care he received whilst in hospital.

The Sheriff principle picks up on these issues and concludes

“in all the circumstances I do not consider that the evidence discloses any reasonable precautions whereby the death of Imran Khan might have been avoided, or that any defects in a system of working contributes to his death. It is not appropriate to make any findings in terms of Paragraphs C

and D of Section 6 (one of the fatal accidents and sudden deaths inquiry) Scotland Act 1976”.

The Sheriff clearly recognises that the comment made in the press was in some circumstances unjustified and goes on to include

“it should not be inferred from the conclusions of this inquiry that everything in the Victoria Infirmary was carried out by the book”. There are plainly imperfections in the notes and the fact that Imran was missed from a ward round on Wednesday and perhaps on the Sunday cannot escape notice, but it would be surprising to expect perfection in record keeping, or indeed in medical practice, in a hospital which receives more than 70,000 patients a year into its Casualty Department alone. Such imperfections are no justification for an atmosphere of near hysterical criticism and the distrust of the Victoria Infirmary that appears to have been generated at least in certain sections of the media and would not have expected a patient with an injury such as Imran sustained to die. The very fact that he did, coupled with the misplaced interpretation of Dr Proctor’s notes, and other factors, including the death of another boy of similar age in the same hospital (albeit in wholly different circumstances), have fuelled the fires of sensationalism. What must be emphasised is that even modern medicine cannot be expected to provide a 100% guarantee of success and that the factors which caused Imran’s death were exceptional. Nothing I have heard leads me to conclude, or even suspect the existence of a general lack of care or want of professionalism on the part of nursing or medical staff at the Victoria Infirmary”.

The way in which such incidents are portrayed within the media is a recurring theme and one which requires comment as part of this research, in as much as the reporting of such circumstances and inquiries, which the Sheriff himself describes as near hysterical criticism innovated at least in certain sections of the media, only serve to destroy the public trust in clinical care provided in your local hospital, which is clearly unjustified. The sheriff’s observation that ‘modern medicine cannot be expected to provide 100% of success’ is also very relevant to the organisational management of clinical incidents. As discussed previously the complex nature of the interactions involved in healthcare delivery, make clinical incidents inevitable. The acceptance of such inevitability, among professionals and the general public, will be a significant move forward in the management of clinical incidents.

Darren Denholm

In the determination of the inquiry into the death of this 10-year-old boy, the sheriff identifies: -

- Seven reasonable precautions by which his death could have been avoided
- Nine defects in the systems of working which contributed to the death
- Seventeen other relevant facts pertaining to the circumstances of his death
- Eighteen recommendations for future practice

This was a landmark case in bringing about the change in undertaking general anaesthetics within dental practices as identified within recommendation 17 of the determination.

‘Consideration should now be given, by the Executive or Parliament if that is required, to the discontinuation of general anaesthesia for dental treatment in dental surgeries and to it being restricted to hospitals with intensive care units.’

This case attracted a considerable amount of publicity and comment within the media and identified a number of weaknesses, which required to be addressed. It would be too simplistic to view this as a death of a child caused by an adverse reaction to an anaesthetic agent, which was identified as leading to the cause of death i.e. a cardiac arrhythmia. A number of other issues in relation to managing clinical risks were also apparent in this case. They included; ensuring that the patient (or in this case their parent) were aware of the risk of treatments, poor communication between the referring and treating clinicians, the process of obtaining appropriate consent, the employment of appropriately qualified medical staff, appropriate training of other staff in dealing with emergencies, lack of monitoring and poor facilities in which to undertake such procedures. It is clear from this particular inquiry that a number of key issues emerged which had an immediate and lasting impact on the delivery of dental care.

Sharman Weir.

In this inquiry the death of a young mother during childbirth was examined. The sheriff in this case made a number of observations with regard to the circumstances surrounded the death. Like the determination made within Darren Denholm case a number of aspects contributed to the events. The inquiry itself was thought to be the longest undertaken in Scotland at that point and the determination of Sheriff Reith is some 124 pages in length and presents a number of issues that are of interest to the study. In this respect the determination is worthy of detailed examination in relation to each of the sections outlined within the Act as being part of the final determination.

Section 6(1)(a): where and when the death and any accident resulting in the death took place. The sheriff states that having identified where and when the death occurred,

‘I have no comment to make on my finding under this sub section. The issue was not in dispute’

Section 6(1)(b): the cause or causes of such death and any accident resulting in the death. The sheriff makes an interesting observation within this section and comments

‘The ultimate cause of death is not in dispute. All were agreed that Ms Weir died of an intra-cerebral haemorrhage. However, the chain of events that led to this is very much less clear.’

Section 6(1)(c): the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided. By way of explanation in this section the sheriff outlines what is required in this part of the determination. There is a detailed discussion about the issues of fault in that the solicitor acting for the medical staff contended that the solicitor acting for the family had used the language of fault, which is inappropriate for an inquiry of this nature. The example cited from the written submission from the family’s solicitor proposed “...the fault lies with the consultants...” This was later modified and the family’s solicitor asked the court to make specific findings in fact in relation to three specific questions.

1. Are the protocols and practices followed by the Queen Mother’s Hospital out of line with standard practice?

2. More subtly, do the doctors in the Queen Mother's Hospital have an insufficient understanding of the underlying balance of risk?

3. Did the doctors correctly appreciate the severity of her condition?

The contention of the solicitor being that the death could potentially have been avoided if the doctors had [a] followed standard practice, [b] had a sufficient understanding of the underlying balance of risks and [c] correctly appreciated the severity of her condition.

The sheriff identifies that she had some difficulty in deciding whether it was appropriate to answer the questions outlined above as they were potentially

‘...inviting a rather wider answer than a finding of facts relevant to Ms Weir’s death and instead inviting a conclusion in relation to the protocols and practices followed by the hospital more generally, which might be more appropriate to a public inquiry into the running of the hospital rather than a Fatal Accident Inquiry such as this.’

This clearly demonstrates recognition that despite the objective of a fact-finding exercise there are some attempts by those involved to establish fault and blame. Whilst the final determination cannot be used in any subsequent civil action it is clear that this is an opportunity to make clearer any issues of liability, fault or cause (as recognised by Levy and McRae 2004) through the inquiry’s ability to detail certain facts.

Section 6(1)(d): the defects, if any, in any systems of working, which contributed to the death or any accident resulting in the death. . It was noted that the solicitor representing the family of Ms Weir was not seeking a determination under this section and therefore this was not commented upon by the sheriff.

Section 6(1)(e): any other facts that are relevant to the circumstances of the death. Within this section the sheriff identifies a number of issues. These are presented in full in order to appreciate the range of issues raised.

(a) that there has been consistent advice in reports on Confidential Enquiries into Maternal Deaths in the United Kingdom ("CEMD Reports") drawing attention to the need for consultant involvement in relation to women admitted to hospital with pre-eclampsia;

(b) that the CEMD Report for 1988-1990 emphasised the continuing lack of awareness of the potential seriousness of seemingly mild symptoms and signs and the treacherous nature of pre-eclampsia, and a persisting failure by consultants to alert junior medical staff to these dangers;

(c) that the CEMD Report for 1994-1996 recommended that each unit should identify a lead obstetric consultant to develop a system for the management of patients with pre-eclampsia and eclampsia. This was to include protocol development and updating, and appropriate staff training;

(d) that a fair and reasonable implication of the CEMD Reports is that it is someone with the requisite experience and insight in relation to pre-eclampsia, including the variability of that condition, who is required;

(e) that the Queen Mother's Hospital has not appointed a lead obstetric consultant to develop a system for the management of patients with pre-eclampsia and eclampsia;

(f) that had Ms Weir been under the care and management of Dr Hanretty instead of Dr Roberts, it is unlikely that a decision for delivery would have been made at an earlier stage;

(g) that had Ms Weir been under the care and management of Dr Cameron instead of Dr Roberts, it is unlikely that induction of labour would have been commenced before the evening of Wednesday 20 October 1999;

(h) that there has been no material change in the system for the management of patients with pre-eclampsia at the Queen Mother's Hospital since the death of Ms Weir;

(i) that it is likely that on Monday 18 October 1999 no doctor of registrar grade (or SHO 3 equivalent) or above was advised of Ms Weir's admission to the ante-natal ward;

(j) that it would have been in accordance with good practice for a doctor of registrar grade or above to have been advised that day of Ms Weir's admission to the ante-natal ward;

(k) that no obstetrician of consultant grade saw Ms Weir until after the acute event at 1410 hours on Thursday 21 October 1999;

(l) that it would have been in accordance with good practice for Ms Weir to have been seen by a consultant obstetrician within the working day following her admission, namely on Tuesday 19 October 1999, in order to determine the immediate and subsequent management in detail;

(m) that in the week commencing Monday 18 October 1999 Dr Roberts' adhered to her ordinary working routine. Her week in the absence of Dr Hanretty on holiday differed only in responsibility;

(n) that the episode of visual disturbance on Tuesday 19 October 1999 was not brought to the attention of a senior doctor;

(o) that it would have been good practice for the episode of visual disturbance to have been brought to the attention of a senior doctor;

(p) that Dr Chitra did not note the systolic blood pressure reading on Tuesday 19 October 1999;

(q) that Dr Branchfield did not note the systolic blood pressure reading on Tuesday 19 October 1999;

(r) that Dr Solanki did not note the systolic blood pressure reading on one occasion on Thursday 21 October 1999;

(s) that it would have been good practice for the systolic blood pressure readings to have been noted in addition to the diastolic readings;

(t) that Ms Weir's blood pressure readings following the visual disturbance on Tuesday 19 October 1999 were not normal, albeit that anti-hypertensive treatment was not required;

(u) that the repeat blood tests which Dr Chitra had on Tuesday 19 October 1999 instructed be repeated on Wednesday 20 October 1999 were not repeated in accordance with that instruction;

(v) that it would have been good practice for the blood tests to have been repeated on Wednesday 20 October in accordance with that instruction;

Within this long and very complex inquiry and its determination it would appear that there is some difficulty in being able to adhere to the objectives of a FAI in not finding fault when there are clearly a number of issues that are very relevant to the events leading to the death. As illustrated above in the comments made by the sheriff in relation to section 6(1) e of the determination there are a number of areas of best practice which patients might reasonably have been employed but the clinical staff involved in this case

and therefore could be regarded as being contributory factors in the death. It is then difficult for interested individuals (in particular, members of the family) not to make what would appear to be a logical step towards apportioning blame. In fact what the determination is outlining are issues of fact and not offering an opinion as to whether it is reasonable to assume that there is cause and effect relationship. The list above demonstrates issues in relation to the available knowledge though the confidential enquiries into maternal deaths, the systems within the institution in which the death occurred and the actions of named practitioners involved in the patient's care. It is therefore understandable that families involved in this legal process sometimes find it difficult to differentiate between the aims and objectives of the inquiry (i.e. to find facts) and their own personal needs (i.e. to find cause that in their minds at least equate to fault and blame).

SUMMARY

The determinations of fatal accident inquiries are a potentially valuable source of information relating the management of clinical risks. They are established in order to determine the facts surrounding a death. It is interesting to note that the determinations made by sheriffs are not presented in a standard format in terms of physical layout of the report or the content. Whilst it may be argued that neither of these issues should detract from the main messages contained within the determination it would be more helpful to organisations and to the families of the deceased if these could be written in a more accessible format. For example, as described earlier there are 5 headings under which each determination is made. If there is no specific comment to make, some sheriffs record that there is no determination to make under that heading, whilst others state that they have not been asked to make a determination whilst another determination simply does not mention that particular section. It is argued that an indication that there is no determination to make is more meaningful than no mention at all.

Whilst it is clearly articulated that the purpose of a FAI is to establish facts and not fault it may be difficult for families to accept that at the end of this process the legal system will not have established who or what was at fault. There is some evidence however

within determinations that there are tactics employed to allow relevant facts to be established which can then be used at a later date although the final determination of the sheriff is not admissible in any later judicial proceedings. However, as Levy and McRae (2004) point out

‘As in 1895 the legislators have recognised a possible area of conflict. In getting to the truth of the cause of death it may be necessary to examine witnesses against whom blame may be levelled. Following the 1895 Act, the 1976 Act provide that the examination of a witness or haver is not to be a bar to criminal proceedings being taken against him. Thus the driver of a car involved in a fatal road accident may be called to give evidence at an inquiry under the 1976 Act and may also be prosecuted under the road traffic legislation. To safeguard his interests to some extent, the Act also provides that no witness is to be compellable to answer any questions tending to show that he is guilty of any crime or offence, a restatement of a well-established rule of law in Scotland.’

It is also interesting to note that there is no statutory requirement for organisations to follow up on recommendations made within determinations. As illustrated within the determination into the death of Darren Denholm, the sheriff has the ability to bring into high relief particular issues, which may require a change in statute, in order to prevent a recurrence. It clearly would be poor and potentially dangerous practice for an organisation not to respond to the recommendations made by a sheriff and would be damning if a similar incident occurred. It is argued that some form of feedback may be useful as part of this legal process to confirm that the issues, which arose within an inquiry have been examined and addressed by the organisation under scrutiny.

DATA SUMMARY

The data generated within the research project has been acquired from a number of different relevant sources in order to facilitate greater understanding of the structures, processes and outcomes of the management of untoward clinical incidents.

- Policy documents from a local and national level have been utilised to generate an understanding of the framework within which individuals are expected to

function. Throughout the period over which the study was conducted a number of policy initiatives were introduced. This resulted in not only an increasing volume of data sources but a moving target in terms of policy frameworks

- The examination of Fatal Accident Inquiries allowed an exploration of the issues relating to how unexpected deaths were examined through the legal processes. These inquiries are not restricted to deaths within health services and therefore provided useful comparison between health and other systems. The comments from the presiding sheriffs outlined specific issues in relation to the circumstances of deaths and whether there were any failures in the system of work which may have contributed to the death. The sheriffs' opportunity to make comment on 'other relevant facts' also proved to be a useful source of data for wider aspects of the study, for example the role of the press in creating the atmosphere in which such events are reported.
- The documentation that has been utilised in managing untoward clinical incidents has been utilised to understand the nature of the incidents which have been investigated within the organisation. These have provided a valuable source of information relating to *how* incidents have been managed, *how many* incidents were managed through this mechanism, *who* was involved in the incidents as well as *who* was involved in their management and some understand as to *why* incidents have been managed in the way they were.
- The interviews with those staff involved provided valuable qualitative data on the perceptions of *how well* these incidents were managed from the perspective of individuals who were responsible for managing the process as well as those who were subject to the investigations.

The final chapter will draw together the themes of the data and develop areas for further debate and discussion as well as making a number of recommendations to improve the management of untoward clinical incidents.

Part 3

The Finding and Concluding Discussions

Chapter IX

FINDINGS

Within the NHS and amongst the general public there is a growing concern about the level of clinical incidents. The present policy, political and professionally driven initiatives seek to minimise the impact of, and wherever possible eliminate the risk of, clinical incidents. The complexity of delivering healthcare and the human interaction involved therein, are such that clinical incidents are inevitable and therefore the management of such incidents must play a central role in a healthcare organisation's clinical governance strategy. The research study set out to examine how clinical incidents involving qualified nurses were managed within an organisation. The study had five distinct phases of data collection and these have been described in Chapters V, VI, VII and VIII. The findings are drawn from all sections and presented with reference to the original aims and objectives of the study.

1. HOW ARE UNTOWARD INCIDENTS INVOLVING NURSES MANAGED?

At a national level a number of policies have been introduced in order to ensure that the management of clinical incidents is improved. These have been driven by initiatives of the various healthcare professions as well as government departments to ensure professional practice does not compromise the effectiveness of healthcare interventions. The analysis of such initiatives demonstrates that some have been more effective than others in improving the management of errors. This is illustrated by the fact that the establishment of a national recording and reporting mechanism for incidents has yet to provide any meaningful information in relation to the quantity and type of clinical errors. The data generated from a pilot scheme undertaken in England and Wales demonstrated a number of weaknesses in relation to the collation of clinical incident information and therefore not viewed as carrying great weight. However, the development of the National Patient Safety Agency has begun to develop service-wide approaches to the management of some very high-risk processes (e.g. the storage and use of high-concentration potassium).

The devolvement of healthcare matters to the Scottish Executive has resulted in differing approaches within NHS Scotland than those developed in other parts of the United Kingdom. The formation of NHS Quality Improvement Scotland facilitated the development of a more integrated approach to the management of risk by bringing together, under a single organisational structure, the clinical elements of risk (previously dealt with through the Clinical Standards Board for Scotland (CSBS)) and the non-clinical elements of risk (previously dealt with through the Clinical Negligence and Other Risk Indemnity Scheme (CNORIS)).

One notable difference between these two elements of risk management (i.e. clinical and non-clinical) was the different assessment processes adopted. The CSBS approach involved self and peer assessment of standards requiring organisations to provide tangible evidence of achievement of given criteria within the pre-determined standards. CNORIS on the other hand adopted an external review process whereby organisations were assessed by an external body commissioned by the Scottish Executive to assess the achievement of criteria. There are advantages and disadvantages to both methods of assessment however it is perhaps the lack of consistency in approach which has attracted most comment. Since these two bodies have come together under the same assessment framework a system of peer review has been adopted to evaluate an organisation's ability to manage clinical and non-clinical risks.

The first report by CSBS relating to the generic standards dealing with these areas of risk concluded that NHS organisations within Scotland had not made the management of risk a high priority. Unfortunately, the new draft healthcare governance standards against which NHS Scotland organisations will be evaluated fall short of articulating clearly achievable standards, a viable monitoring mechanism and a feedback process for the introduction of improved systems of working. The alterations made to standards and assessment methods as a result of the amalgamation of the evaluating organisations will also mean that it will be difficult to identify whether an organisation has improved its risk management processes from previous assessments. There is little evidence within the draft governance standards that the available literature regarding incident and error

management has been referenced in relation to the development of criteria within each standard statement.

The problem of accurately and consistently defining an untoward incident remains. Within NHS Scotland there is no recognised system for defining incidents and therefore there are no accurate data relating to the incidence and prevalence of clinical incidents overall. Consequently, there is no accurate assessment as to the level and nature of incidents involving qualified nurses. The literature contains a number of studies, which attempt to quantify the level and nature of clinical incidents but all acknowledge the difficulty in determining a more accurate understanding of the problem and identify a number of reasons for this. There are no studies available, which examine exclusively incidents involving qualified nurses and therefore the quantity and nature of incidents seen within this organisation cannot be compared with others.

The difficulties in obtaining a clearer understanding of the number and nature of errors identified within the literature were reflected within the subject organisation. In the main these include the fact that errors are not recognised as being errors and therefore cannot be reported as well as individual clinicians failing to report recognised errors. There was also evidence that some nurses did not fully understand that all recognised errors should be reported. Whilst the study ultimately did not examine in detail policies and procedures from other NHS organisations, the structural organisational changes within the NHS over the past 15 years had seen a move away from a centralist approach to a more local devolved managerial approach. This freedom resulted in the adoption of a number of different processes within different organisations. The more recent move back to a centralist approach which brings these disparate systems together has served to illustrate these differences. During the interviews both nurses and managers commented on the potential difficulties when the organisation became part of a wider, single NHS entity. The lack of a consistent approach does not allow at either a local or national level the opportunity to benchmark error rates. The lack of consistency also prevents a national overview of the errors and their impact.

Local Policy Development and Implementation

At an individual organisation policy development and implementation level, the management of clinical incidents has been incorporated into the overall clinical risk management strategy within the study organisation. Previously, different types of incidents were managed through different processes. Some were managed as ‘accidents’ and managed through a health and safety system. Some were managed as ‘clinical incidents’ and managed through the relevant clinical hierarchy. Some were managed as ‘incidents’ and managed through a local recording and monitoring process. In relation to clinical incidents involving nurses, these were managed through the nursing management structure. Within this there was a degree of confusion as to what constituted an ‘accident’ and what could be reasonably be described as a ‘clinical incident’. These apparent artificial boundaries were recognised and the policy framework was reviewed and altered to take account of, and rectify these apparent anomalies. The analysis demonstrated that the policies and procedures were not being rigidly adhered to and this was argued as demonstrating a flexible application of policy to different situations.

The organisation has developed an incident policy designed to deal with a broad range of incidents, accidents, near misses and those incidents that require to be reported through the national health and safety structures (RIDDOR) scheme. The single reporting structure also required that a standard incident form be used in all cases. This does raise the question as to whether clinical incidents involving nurses should be managed through a discrete mechanism. The perceptions from a number of the respondents in the interviews was that nurses were *de facto* the only discipline to follow the systems set out for investigating incidents. Whilst the main comparisons were made in relation to medical practitioners, comment was also made in relation to allied health professionals. There was little evidence to suggest that incidents involving nursing staff should be managed within a discrete process. However, it was reported that it was essential that nurses lead the process of investigating incidents involving other nurses.

There is one group of incidents where consideration should be given to having a discrete, additional process i.e. medication errors. The frequency, nature and complexity of these errors are such that these would merit a separate process and additional information could be retrieved and used as part of a feedback mechanism within the organisation to help improve the management of medicines. This was not evident in the subject organisation (although some respondents were aware of discussions around this development) and as a result there was an incomplete picture of the circumstances of the medication errors and the potential actions to resolve any weaknesses. This was exacerbated by the lack of involvement of other healthcare professionals whose skills and expertise would add significant value to the process (e.g. clinical pharmacists)

The sentiments expressed within the subject organisation's policy document were not reflected consistently in the way incidents are managed. Those who were interviewed did not feel that the organisation had yet reached a stage where the managerial processes were 'positive and non-punitive' (the aspiration outlined within the study organisation's policy). There was recognition that recent changes within the organisation were now beginning to have an impact in the way these issues were being addressed. These changes included the adoption of a root cause analysis process and the appointment of a risk manager who had a specific role in managing the process. Some nurse managers described approaches to managing incident investigations during the interviews, which did not match the reality of completed investigations. Where this was evident the description offered during the interview tended to reflect the statements within the policy and described a 'positive and non-punitive' approach. The evidence from the nursing staff and the examination of the outcome of incidents would suggest a negative and punitive approach. There were examples where this was not the case. At the stage of the policy implementation it would be difficult to attribute such changes to the new policy or simply to approaches adopted by individual managers.

Managerial Approach to the Management of Incidents

The policies tend to be used flexibly by those managers who felt comfortable with their own management style and approach but tended to be interpreted and applied rigidly by

managers who were less experienced or who had not been involved in managing clinical incidents previously. There was no attempt within the study to examine the personal or professional attributes of the individual managers involved in managing the incidents under investigation. However, nurses who were the subject of the investigative processes were able to identify traits in managers who adopted particular styles and approaches.

A number of themes emerged from the examination of incidents and interviews. Managers were more likely to follow a disciplinary process whilst some managers more likely to follow a 'reflective' / educational process. It was observed by a number of those interviewed that managers who demonstrated 'traditional nursing officer' traits (i.e. the approach described by Bassett as the scientific approach to management) were more likely to follow a disciplinary approach. This managerial group was observed to have spent most of their career in an acute, general hospital, hierarchical environment. It was observed that nurse managers with mental health / psychosocial backgrounds were more likely to follow the reflective / educational process (i.e. a similar approach to that described by Bassett as the behavioural approach to management.). It was also notable in some instances where managers described a more behaviourist approach to the management of incidents but the reality demonstrated, through the documented incidents and interviews, the application of the scientific approach.

Some managers found the process of undertaking an investigation a difficult one in terms of being able to find the balance between holding nurses to account for their actions, supporting them through a traumatic episode and at the same time establishing the cause of an incident in a non-threatening manner. There was some evidence that managers were attempting to obtain feedback about the processes in order to improve the management of the situation. Being able to obtain meaningful feedback in order to evaluate the effectiveness of an investigation was seen as difficult.

Nurses' Views of the Approaches Adopted

The processes of managing clinical incidents were regarded by those staff subjected to the investigation as threatening and on occasions were described as hostile. The

perception of nurses remained one in which blame is sought to be attributed to an individual rather than seeking an understanding of the causes of an incident. There was evidence to suggest that some of these perceptions are borne from a feeling of guilt rather than an overt blame by the organisation. There are some very clear demonstrations of investigative processes designed to examine the systems of work and processes rather than concentration on the role an individual has played. These are however very few and have not been adopted across the organisation. These were also only applied by a specific manager and did not follow strictly the policy in place at the time. The implementation of a new policy, which adopted the approach recommended by the National Patient Safety Agency (NPSA), i.e. root cause analysis, was a significant move towards ensuring that clinical incident investigation concentrated on processes and systems rather than individuals.

This approach was very new at the time of the research and those involved in its early implementation reported that there was a degree of nervousness around its implementation. Whilst this was acknowledged as being the normal reaction to novel policies and procedures there remained a perception that this was a managerially driven process designed to find and apportion blame. This pointed to the fact that no matter what approach was taken by the organisation it would be perceived by those who were involved in the incident that the system was designed to find fault. As stated earlier this may be more related to the feelings of guilt experienced by nurses rather than overt attempts by the organisation to apportion blame. It may however also be related to the fact that the organisation continued to have in some cases a disciplinary 'investigative' process alongside this new root cause analysis. It was reported that in some cases there was confusion around the order in which these processes were conducted i.e. should the root cause analysis be completed before or after the disciplinary investigation?

During the interviews it was reported consistently that nurses only accept other nurses undertaking investigations into incidents involving nurses. A number of different explanations were offered for adopting this view. These included that only nurses would

appreciate the professional issues involved within a given situation and that it was the duty of the professional to manage and regulate itself and thus maintain self-regulation.

Working in Partnership

Staff organisations were involved in managing clinical incidents, adopting a partnership approach, in line with national HR strategy. Managers and nurses expressed different views on the effectiveness of the partnership approach and were able to quote both good and bad experiences of managing incidents where nursing staff were represented by their trade unions. One manager described how they had attempted to manage clinical incidents without the need for the involvement of staff representatives, believing that this was 'better' for both the organisation and the individual member of staff. Whilst they perceived their motives to be straightforward and 'fair', this was not a view shared by staff organisations that perceived such actions as trying to 'punish' their member without the 'protection' of their representative. Another manager's perception was that staff organisations' actions resulted in being 'forced' into taking disciplinary action where it was not merited. This demonstrated that perhaps lip service was being paid to the concept and principles of partnership working, where the reality was one of mistrust and ulterior motives. This was balanced by some very clear examples of managers and staff organisations working together to undertake thorough investigations into clinical incidents without necessarily concentrating on the role played by individuals but concentrating more on systems and processes.

Documentary Evidence Available

A number of different forms of documentation were utilised in the management of incidents and were reviewed as part of the study. The research studies explored within the literature review identified consistently the need to improve the quality of documentation. This study reaches the same conclusion. The documentation expected by the organisation to be completed as part of the management of clinical incidents was available in only a small percentage of the cases reviewed.

There were considerable inconsistencies in the quality and quantity of the supplementary documents utilised. For some important parts of the process there were apparently no documents to demonstrate the process, content and outcome of investigative meetings. There was a lack of consistency in the terms used even in similar incidents within the same managerial units. It was evident that the investigations undertaken by not following the policy produced reports, which were more descriptive in relation to the incident itself, the process of investigating the incident, its outcome and any agreed actions. The conclusion from this method would arguably be that where qualified nurses are free to use less bureaucratic methods of reporting and recording methods in the management of an investigation, the final reports are richer in terms of quality and quantity of information. Perhaps more importantly in terms of understanding of the role of systems as well as the role of individuals, this method was more effective in determining the source and cause of an incident. In relation to how blame is apportioned this is also an important feature as it may be that the process and the need to strictly adhere to the bureaucratic documentation are in themselves factors tending to promote the apportioning blame to individuals inappropriately.

2. ARE CLINICAL INCIDENTS MANAGED CONSISTENTLY?

There is a perception among the nursing staff that there are inconsistencies in how similar incidents are managed. A number of variable factors were identified as having an impact on the management and outcome of a clinical incident. The perceived inconsistencies were noted both within and between managerial units. The variable factors included the experience of the manager, the managerial unit, the trade union representation and nature of the incident. There was also concern expressed that there appeared to be inconsistencies in the outcome of investigative processes. Recorded outcomes within the documentation confirm this view.

The evidence from documented incidents and semi-structured interviews suggests that as well as inconsistencies in procedures there were significant inconsistencies in the eventual outcome. Once again this was evident within and between managerial units of the organisation. This was illustrated in particular through medication errors. It was

evident that investigations into medication errors had a number of potential outcomes or combination of outcomes. These might include, no action, disciplinary action (there were a variety of levels of disciplinary action possible, ranging from an oral warning, through to dismissal), undertaking a reflective process, additional education and training and supervised practice. Nurses identified similar medication errors with very different outcomes e.g. additional education and supervision in one case and severe disciplinary action and threats to employment in another. Controlled-drug errors tended to be managed through the disciplinary processes as both clinical nurses and nurse managers regarded these as more serious errors, irrespective of the outcome to the patient.

Common themes began to emerge in relation to nurses' perceptions of managers and the likely outcome of incident investigations. It was observed and reported by nurses who participated in the interviews that inexperienced managers were more likely to follow a disciplinary route than experienced managers. A consistent finding during the interviews was that nurses who functioned within a managerial culture using the disciplinary approach were less likely to report incidents particularly where there has been no obvious harm to patients; and nurses who functioned within a managerial culture using a reflective approach were more likely to report incidents irrespective of the outcome.

There is a clear view that doctors are managed very differently as a result of an untoward clinical incident. Many of the individuals who were interviewed acknowledged that this was a perception rather than a reality in that, due to the confidential nature of such investigations, they were not fully aware of the outcome of incidents involving doctors. There was a widespread perception that the organisation policy for the management of clinical incidents should apply to all staff but was rarely if ever applied to medical staff. This adds to the overall view that the nursing hierarchy tends to seek to blame individual nurses when something goes wrong.

Managers reported that they tried to differentiate how clinical incidents were managed according to the nature of the incidents. This was illustrated through the way in which less serious incidents were managed in a less formal manner and were managed utilising

a reflective approach. More serious incidents were managed through the investigation process. There was no consistency however in what was described as a 'minor incident' and what was regarded as a 'major' incident. This once again left the nursing staff involved in the incident unclear as to why apparently similar incidents were being managed differently with different outcomes.

There was an inconsistent approach as to how and whether patients were informed about a clinical incident or a near miss. Some reported that it was so obvious to the patient that an error had occurred that not to tell the patient would be counter-productive. Others described circumstances where it would be difficult for the patient to understand what had happened. Managers and nurses felt that there was a lack of guidance on the matter and were even unclear as to who should make the decision as to whether the patient should be told. The patient's consultant was seen as being the ultimate arbiter on this decision. This matter being left to individual discretion was felt to lead to an inconsistent approach.

3. HOW IS THE OUTCOME OF SUCH INVESTIGATIONS USED TO INFORM CLINICAL NURSING PRACTICE?

There was very little evidence that any lessons learned from the clinical incidents were shared either within or between managerial units. Where this was evident it was usually undertaken at a personal and informal level. Some concern was expressed at the ability to share such information whilst at the same time maintaining the confidential nature of the incident, its management and the anonymity of the nurses involved. At the same time it was acknowledged that the organisation's grapevine was very often a vehicle carrying this information anyway. There are a number of methods, which could have been adopted to ensure that anonymous examples were used to illustrate issues and ensure lessons were learned. It was clear that there were some fora through which this information could be filtered. Those involved in the incidents on the whole tended to receive little in the way of formal feedback.

It was notable that nurses rarely used the clinical governance framework to explore the causes of incidents and errors or to use this mechanism to disseminate the lessons learned from the process. There was a perception that this was in the main a medical mechanism and that any multi-disciplinary discussions were restricted to patient pathways or specific problems relating to the processes of delivering healthcare and on some occasions issues raised through patient complaints.

The documentary evidence suggested that there was little in the way of follow-up to education, training and supervised practice. Where this was available it was restricted to a short report from the ward manager indicating that they were satisfied that the individual involved was competent to undertake a particular process. However, during the interviews it was reported that the feedback tended to be more formalised and it was accepted that this type of information was more likely to be recorded within an individual's personal files rather than in the incident documentation. This data source was not accessed as part of the research study.

During an investigation, circumstances in mitigation were often used to explain, at least in part, why an incident might have occurred. Managers reported that these were often presented no matter how relevant. The most often quoted being a lack of available staff. It was acknowledged that this may be relevant in a small number of cases however in many there could have been additional staff around and the incident would probably still have happened.

Systems have been developed to enhance the learning opportunities for individual members of staff. These include reflective exercises designed to allow the individual nurse to take some time to reflect on what has happened, how it happened, how it could be prevented in future and the identification of skills and knowledge gaps. There are some examples of additional training for nursing staff in policies and procedures relating to the incident in which they were involved. It was reported that these were effective but there is little in the way of documented evidence that they had been completed or had been instrumental in reducing the incidence of errors.

4. WHAT ROLE DOES BLAME PLAY IN THE PROCESS?

It was consistently reported by qualified nurses that senior nurses involved in the investigation of an incident sought to blame and punish a nurse for their role within an incident, as opposed to reviewing systems and processes potentially contributing to an error.

Nursing staff reported that they were aware that other nursing staff are reluctant to come forward when they had committed an error. The reasons cited all related to the fear of reprisals which included reduction in professional standing, loss of confidence in the nurse's ability by managers, disciplinary action, fear of dismissal, permanent record of incident and impact of future employment prospects. These reflect findings in other studies reported in the literature review. Despite this view managers interviewed reported that the use of the documentation relating to incident reporting was being utilised more effectively previously. However, the majority of those interviewed recognised that errors were not being reported due the fear of reprisals and the fear of being blamed.

Both managers and nurses reported that a blame free culture was neither realistic nor desirable. There was recognition by both groups that there were circumstances whereby individuals should be held to account for their actions or inactions and hence blamed. All those involved found it difficult to articulate the difference between what some described as 'human error' and actions which merited formal action. Both groups recognised this in relation to nursing and expected that doctors should be managed within a similar system. It was perceived there was no justification for doctors to be managed differently in relation to untoward clinical incidents. There were mixed views as to whether the system adopted by one group was more effective than another. Whilst recognising that there were differences in the views expressed it was clear that the process adopted by doctors was too informal, and that adopted by nurses was overly formalised. A balance between the two was therefore seen as the most appropriate method. The organisation has worked towards developing a 'just' culture. This could be expanded as a fair and just culture. These terms are currently not used within the policy documentation.

Nurses demonstrated attribution tendencies in both directions. Attribution away from self to other obscure organisational issues tended to be displayed by more senior nurses (i.e. charge nurses were more likely to look to organisational issues to which they could attribute the cause). More junior staff were more likely to attribute the cause of errors to themselves and accept that they had committed an error. It was reported throughout the interviews that in this latter case, for the individuals who adopt this approach, the organisation could not punish the individual more than they were punishing themselves and disciplinary action was therefore pointless. Often in investigations organisational issues were presented as mitigating circumstances. There were mixed views as to the appropriateness of these factors in determining the root cause of the incident.

5. HOW CAN FATAL ACCIDENT INQUIRIES ASSIST IN THE PROCESS?

Fatal Accident Inquiries (FAI) were found to be a useful source of information with regard to providing a considered view as to the cause of death and where there may be faults in the systems of working which may have contributed to the cause of death. In particular the sheriff's determination may be helpful in counteracting negative publicity often generated in these circumstances. The FAIs examined included a number involving settings other than hospitals although the majority related to deaths which had occurred within a hospital setting.

It was interesting to note that the sheriff's final determination did not conform to a standard format. This applied as much to the physical layout of the report as much as to the way in which an individual sheriff handled each section of the determination. It could be argued that there is little to be gained from adopting a very strict and uniform approach to such reports. However, if they are to be useful reports to organisations, an individual involved and indeed to the families of the person whose death is being investigated, then it is argued that these could be presented in a consistent and accessible format. There are six sections, which should be included in the final determination. In some reports where the sheriff has nothing to determine under a particular section there is simply no mention of this section. In others the sheriff states that he/she makes no

determination under that section. In others the sheriff conclude that he/she has not be asked to determine under certain sections and will therefore make no comment.

The final determination is expected to follow the specific sections detailed earlier and that does include a section for 'any other relevant facts'. This offers the sheriff an opportunity to deal with any specific pieces of evidence that do not fall neatly within the earlier sections. This includes detailed organisational and individual issues and this has the potential to detract from the principle of fact-finding rather than fault finding as in reality the sheriff in some instances is pointing to 'faults' within organisations and individuals. Whilst the organisation under investigation had no FAIs relating to them this section can be particularly useful as a learning opportunity for other organisations as it was often regarded as 'there but for the grace of God...' That said there was no evidence from any of the documentation or interviews that issues and / or lessons from FAIs had been circulated throughout the subject organisation. As stated earlier in particularly high profile cases there has been mis-representation of issues within certain sections of the media. In some determinations the sheriff took the opportunity to redress the balance. This is particularly relevant in cases where reporting contributed to a loss of trust within individuals and organisations. However, it is also acknowledged that such remarks made by a sheriff against the commentary are then rarely reported widely if at all.

The final observation in relation to FAIs is that there is no formal mechanism for addressing any system defects identified during the inquiry. The sheriff may make a number of recommendations relating to various aspects of individual practice and systems within organisations and there appears to be an assumption that these will be addressed by organisations. It is clear that any organisation that failed to address these points would be placing itself at further risk, however the legal process is then complete and there is no requirement for an organisation to demonstrate that it has addressed the issues. The need to 'close the loop' in relation to any systematic review is a well-established principle. In audit processes, it is expected that having identified an issue, action is taken and the cycle is completed through some form of re-measuring. It is remarkable that the legal process, dealing with clinical incidents, which have the most

extreme impact on a patient, has no formal requirement to complete the cycle and ensure that its findings are accepted and recommendations are implemented. Fatal Accident Inquiries and the determinations produced as a result of such inquiries are in a position to take a procedural lead in demonstrating how such investigations could be conducted at an organisational level in order to establish facts and not fault and that the outcomes must be used productively to prevent recurrence. The evidence within this research study suggests this is an opportunity missed. It is suggested therefore that a process of feedback to the Sheriff Court could be developed, through which organisations must demonstrate that the systems have been rectified.

Chapter X

CONCLUDING DISCUSSION AND PROPOSED MODEL

Chapters V-VIII presented the data generated from this study. Chapter IX outlined the findings drawn from the data and how they related to the available literature. This final chapter outlines a proposed model to improve the management of clinical incidents and provides a rationale for the various elements of the model. In the final section of this chapter the issues that emerged from the findings are explored and suggestions made for further research in the field.

A PROPOSED MODEL

It is clear from the findings that the lack of a consistent approach to the management of clinical incidents has a significant impact on individual nurses, managerial units and the organisation as a whole. It is also evident that organisations cannot look to the legal processes for a lead in relation to best practice around the management of incidents. Therefore a model for the management of clinical incidents is presented. The model draws on the work of the NPSA, in devising a nationally recognised methodology for undertaking a root cause analysis. It also adapts the work undertaken by Merry and McCall Smith in relation to blame and presents a method of attribution based on the same principles but removes the negative connotations associated with 'blame'. It facilitates an understanding of the difference between an error and a violation. Finally it directs the management of the process towards ensuring the organisation reacts appropriately according to the cause of the incident and ensures the information gleaned and lessons learned from the incident are fed through the organisation's clinical governance processes. The model has 5 stages and is titled using the acronym RADAR – **R**ecording, **A**nalysis, **D**efining, **A**tribution and **R**eaction (This should not be confused with RIDDOR which is a health and safety reporting mechanism). Whilst this research sought to examine clinical incidents involving qualified nurses, the issues raised suggest a common system of managing incidents and that any specific professional nursing issues arising as a result of an incident can be addressed either within the proposed framework

or dealt with separately. A diagrammatic representation of the model is provided within appendix 4

Reporting

Within the literature there was considerable debate in relation to whether incidents and near misses should be reported using an anonymous process. Evidence from other industries (for example aviation) would suggest that there are a number of advantages to an anonymous reporting system and it is suggested that this is the most effective way of obtaining the relevant information in relation to error management. Within healthcare there remains a degree of scepticism, from patient and professional groups about the use of anonymous reporting within health services. However, there are some very effective and fully evaluated systems within healthcare that have employed successfully an anonymous format. To this end the model suggests that both methods are included within the process; an anonymous format for near misses and a non-anonymous format for actual incidents. Both types of incidents are required to be investigated by the organisation.

Actual Incidents: These are reported as part of a local recording system or where appropriate through a national process (e.g. RIDDOR). There is a need to develop a national system for all clinical errors. This would facilitate a greater understanding as to the quantity and nature of clinical incidents and would also provide a framework for benchmarking of error rates and the dissemination of lessons learned across the whole system. In order to investigate fully the circumstances surrounding an incident it is important that this system is not an anonymous reporting system.

Near Misses: These should form part of a local recording system and should be an anonymous reporting system whilst ensuring that sufficient information is gathered in order to identify the cause and potential impact of a near miss. This information can then be disseminated throughout the organisation in order that practitioners are aware of a potential hazard and can prevent a near miss becoming an actual incident sometime in the

future. This investigation could be undertaken using a modified root cause analysis method

The findings from the research suggest that the standard documentation provides little information beyond the basic demographic details required for each incident. The most informative reports are those that are more descriptive and follow a similar form to a critical incident technique. The research study also demonstrated that the investigations involving a physical walk through the process with the appropriate individuals, provided the clearest explanation of the cause of the errors and was also able to demonstrate the inter-relationship between the working environment and the individual who must function within it. By producing investigation reports using this method the process of analysing the data will be more effective in establishing weaknesses within systems, roles played by individuals and identifying any actions required to rectify problems and by whom.

Analysis

The next stage of the process is to undertake an analysis of the information gathered as part of the reporting mechanism. The perceived inconsistencies reported within the study suggest that a standard framework for undertaking an investigation is required to identify the root cause of an incident. The evidence from this study suggests that the more qualitative data gathered the more effective the action plan to change systems and improve patient safety. The NPSA method provides an opportunity to review the antecedents to an incident and identify the causes. The analysis will allow the identification of a cause category. There are 7 potential cause categories. These are;-

- Patient
- Individual staff
- Team
- Task
- Working environment
- Management and organisation
- Institutional context

There are 3 main advantages to adopting the NPSA model of root cause analysis; (1) It assures a consistency of approach within an organisation, (2) It assures a consistency of approach between different organisations and (3) It enables a full analysis of all factors contributing to an error

From the analysis, causes relating to organisational issues can be addressed possibly without further recourse to the roles played by individual members of staff and therefore ensure the focus of defining the root cause of the problem rather than concentrating on the role played by individual members of staff. This once again would reflect the findings in other studies and begin to foster a systems approach rather than a person approach to error management. It also allows the investigation to identify any specific issues relating to patients rather than staff and organisation-related aspects. The information glean from the analysis can then be used to identify an error as opposed to a violation and move into the next phase of the model.

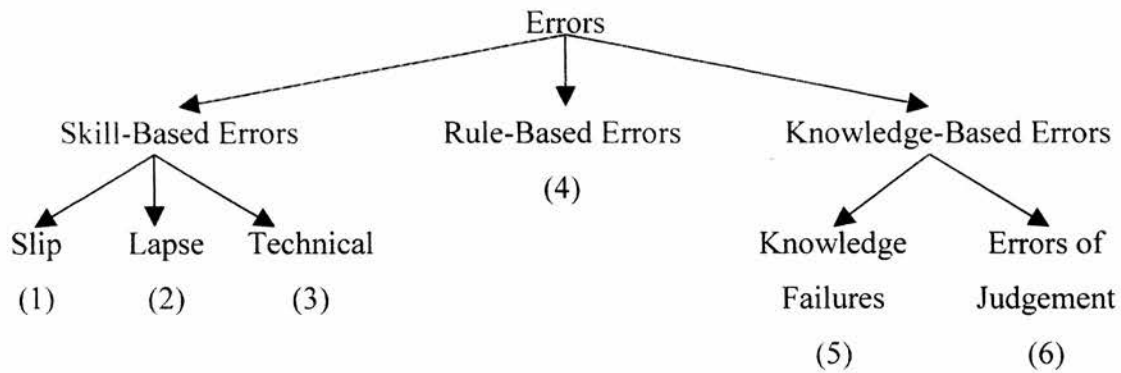
It was clear from the evidence within the study that another nurse should investigate incidents involving nurses. It is suggested that an approach should be adopted that does ensure that nurses are involved in all investigations involving nurses and that this can be achieved in a number of different ways. The model does not offer any particular method but suggests that the approach will be determined by the nature of the incident. For example in a medication error it may be appropriate for the analysis to be undertaken by a clinical pharmacists with professional support and advice from a nurse. In an incident examining nursing practice exclusively there may be no need for any other discipline to be involved.

Defining

This stage allows the investigation team to define the error or violation in relation to the root cause. By defining these it is possible then to determine the most appropriate action at both an individual and organisational level. To make this meaningful there needs to be consistent definition of error and violation. The model presents the definitions outlined by Merry and McCall Smith as being the most appropriate to be used.

Error: An error is an unintentional failure in the formulation of a plan by which it is intended to achieve a goal, or an unintentional departure of a sequence of mental or physical activities from the sequence planned, except when such a departure is due to a chance intervention. (Merry & McCall Smith)

An error can then be categorised as a skill-based error, rule-based error or knowledge-based error. These can then be sub-divided as demonstrated below.



1. *Slips* - something is done which was not intended as a result of a failure of attention. An act of commission. For example a nurse gives a drug to the wrong patient as a result of being distracted during a medication round.
2. *Lapse* - something is not done which was intended as a result of a failure of attention. An act of omission. A nurse does not administer a dispensed medicine to a patient having been called away to take a telephone call.
3. *Technical* - a skill-based error, which is distinct from a slip or a lapse. There are two main factors, which relate to technical skill-based errors in medicine (1) patient variability (2) practitioner variability. Practitioner variability can relate to difference between two different practitioners or related to one practitioner but in different circumstances.
4. *Rule-based errors*: A failure in the process by which a set of circumstances is recognised and an appropriate rule applied. Either due to pattern of events is

incorrectly recognised and matched to an inappropriate rule. Or due to the application of a wrong or inadequate rule to correctly matched mental schema.

5. *Knowledge failures*: Those situations where the fault lies with the information recalled from the individual's internal store of knowledge. This may be due to either a failure of memory or the individual did not have the knowledge.
6. *Errors of Judgement*: The decision may have produced the desired goal but didn't. The outcome is a poor guide of quality of decision. The decision should be called an error only if unsound for example is there a fault in logic or a deficiency in the information

'Violations: A deliberate – but not necessarily reprehensible – deviation from those practices appreciated by the individual as being required by regulation or necessary or advisable to achieve the appropriate objective while maintaining the safety of people and equipment and the ongoing operation of a device or system.' (Merry and McCall Smith)

As discussed previously differences between an error and violation relate to the element of choice. In an error the actor has no choice and in a violation the actor has chosen to deviate from defined or accepted practice. Throughout the study and within the wider review of the literature there was an acceptance that, where appropriate, individuals must be held to account for their actions. Within the context of clinical incidents this differentiation will allow this to happen. Nurses throughout the study attempted to identify those incidents for which someone should be held to account and ultimately be punished. There were attempts to identify how these would be differentiated and factors would include the outcome (for the patient), whether controlled drugs were involved and whether the individual member of staff was able to appreciate what had happened and the actual and potential consequences of their actions or inactions. There was some difficulty in being able to apply these without the outward perception that there was an inconsistency in approach. The proposed model allows these to be clearly defined and to maintain a consistent approach across different types of clinical incidents.

Whilst the research did not attempt to seek the views of patients within the literature it is clear that there is an expectation by patients and their representatives that individual

practitioners should be held to account for their actions. It was also clear that the culture of wholesale blame was not a reasonable culture and that a balance should be achieved. It is suggested that the proposed model in being able to differentiate between an error and violation as well as being able to identify the root cause(s) would offer then an opportunity to provide them with a fuller explanation of what happened, the cause of the error and the planned actions to rectify any problems.

Attribution

The fourth stage of the process involves attribution of cause. It is suggested that the levels of blame outlined by Merry and McCall Smith are adapted for this purpose although the term blame is removed for two main reasons. Firstly, the term has very negative connotations and the avoidance of its use will go some way to removing some of the negativity that accompanies clinical incident management and as a result encourage individual practitioners to report incidents. It is suggested that this may remove one of the barriers to practitioners reporting incidents. The second reason is that the definitions outlined by Merry and McCall Smith relate in the main to the technical definition of blame as applied by the law, which do not fully translate into situations managed within an organisational rather legal context. The suggested term is attribution rather than blame. The proposed five levels of attribution are defined in table 12

Table 12: Levels and Definitions of Attribution Adapted from Merry and McCall Smith’s Levels of Blame

Level	Definition
1	Attribution is to the causal effect where an individual may be the physical cause of the effect but has acted reasonably has broken no rules and has done nothing wrong in moral terms
2	Attribution is to a failure to achieve the theoretical norm i.e. this is a deviation from what would be described within a textbook.
3	Attribution is to a failure to achieve the empiric norm i.e. this is a deviation from what would be recognised as current practice within the field
4	Attribution is to a course of action knowing the existence of risk and may be described as reckless
5	Attribution is an unambiguous intention to cause harm.

Reaction

The final stage of the process is the organisation’s reaction to the attribution. At this stage the information generated from the previous stages can be used to inform how the organisation will react to a given situation. The reactions will be related to the root cause and attribution and will be focussed on either the organisation’s working systems or where appropriate on the conduct or capability of individual practitioners. This acknowledges that there are incidents that individuals have contributed to as opposed to a flawed system of work. It also acknowledges that the role the individual played is related to either their conduct or their capability. As such where an incident has occurred as a result of someone’s conduct there can be appropriate measures taken. If however there are issues relating to capability these can be addressed in an appropriate albeit in a different way from conduct. The levels and types of reactions as outlined within table 13.

Table 13: Levels and Definitions of Reactions

Level	Definition
A	A review of the organisation’s systems and may have implications wider than the organisation.
B	A review of the current literature in order to understand the current theoretical thinking.
C	A review of current practice. Additional education / supervision for the staff involved.
D	A review of the individual’s actions, which will determine whether the issue is one of conduct or capability.
E	A review of the individual’s conduct and referral to appropriate authorities.

The outcome of the above should then be included in an anonymous format within the organisation’s clinical governance framework. This will facilitate the dissemination of lessons learned to all parts of the organisations as well as ensuring that any changes to systems as a result of the outcome can be shared to prevent recurrence.

In this model it is recognised that errors are an inevitable part of the delivery of healthcare. It determines the root cause(s) of the incident using a system divorced from the disciplinary process. It describes and categorises the types of errors as outlined within

the literature relating to the theory of errors and their management. It directly relates these types of errors to an appropriate level of attribution, which in turn determines the relevant course of action. This may on occasions result in blame being directly attributable to individuals but more importantly it will direct the organisation to weaknesses within its systems and processes and as such identify where action needs to be concentrated if the incident is to be prevented from recurring.

It must be recognised that the proposed model is not indented to be prescriptive. It is not intended to be a substitute for the professional and analytical processes employed by nurse managers during investigations, it is indented to be a framework within which such managerial actions can be undertaken. The wide variation in the type of incidents as demonstrated within the study organisation, means that it would be very difficulty, and arguably counter productive, to have a model which would be able to cover all potential incidents. The model also recognises that each incident will have unique elements that would not necessarily fall within the model and therefore must be managed by the expertise of the individual manager.

The rationale for this model is now explored taking into account the conclusions drawn from the data generated within the study and the themes that emerged from the literature review.

NURSING APPROACH TO MANAGING INCIDENTS

The concerns of how nurses are managed in relation to clinical incidents within the literature are reflected in the findings of this study. Although there is limited information within the literature specifically in relation to nurses, the study concludes that the lived experiences of nurses and managers within the study reflect many of the issues raised within previous research. This would lead one to believe that there are qualities within nurses and nursing, which influence this approach. In the literature review the research examined some of the history of nursing and its relationship with other disciplines, in particular medicine. It concluded that the development of nursing is closely linked with the social changes experienced by women throughout the same period. However, the

development of the nursing professions has resulted in nursing moving away from its dependence on medicine therefore there can be little scope for attributing some of these issues to the patriarchal role played by medicine over nursing. The review also outlined some of the arguments relating to the view that nursing and women's issues were linked to the exclusion of any impact on men's issues either in society or within nursing itself. The conclusion is therefore that nursing practice and management continues to be influenced by its militaristic and religious origins. This is not to argue that nursing practice has a military or religious basis but that there are traits relating to hierarchy, strict adherence to rules and regulations and the maintenance of a clear order, are characteristics that remain despite the changes which nursing has seen.

NURSES INVOLVED WITH CLINICAL INCIDENTS

The nurses within the cohort of interviewees had a wide range of experience and backgrounds. There was a mix of newly qualified staff as well as more senior staff who had been qualified for a considerable number of years. The experiences of nurses varied considerably and there are a number of factors contributing to these experiences. Whilst the main aim of the research was to explore the issues of blame one further concept began to emerge from the data – guilt. Individuals expressed that they were being blamed for what happened by the organisation and many did express this as the organisation rather than individuals or specific roles. It is therefore suggested that the emotions expressed as being blamed could be more related to a feeling of guilt, therefore deflecting the cause of negative emotions away from themselves onto a faceless organisation. The guilt may be derived from the fact that the nurse actually or potentially harmed a patient, or that they had compromised their personal or professional standards. This would not hold true for those individuals who did not recognise the implications of their actions.

This however does not detract from individuals with the relevant authority to punish people as a result of an error. It is suggested through this research that the problem lies in not being able to differentiate between what constitutes an error and what constitutes a violation. The differentiating factor between error and violation, as defined by Reason, or Merry and McCall Smith, is intent, or more accurately choice. Intent has a very specific

meaning within the law and there is the potential to take a literal meaning of intent from a legal perspective. Errors are by definition unintentional and violations are intended in that the actor is aware that their actions are contrary to what is expected of them. In understanding these definitions in light of the information gathered throughout this research it is suggested that one way of improving the management of untoward clinical incidents is to differentiate between what is an error and what is a violation. This allows there to be a clear definition of how these should be handled. When this is combined with the levels of blame which are suggested by Merry & McCall Smith then the development of an algorithm provides some guidance to all those involved as a means of understanding what has gone wrong, why it has gone wrong and what would be suitable actions as a result.

The study demonstrated through the experiences of those involved (either as an investigator or as someone who has been the subject of investigation), that nurses tend to take a punitive approach to the management of untoward clinical incidents. This was coupled with a lack of consistency in how errors were managed. This applied to similar errors both within and between managerial units within the organisation, and is despite working within the same policy framework.

In order to improve the management of untoward clinical incidents involving qualified nurses there is a need to alter radically the approach being taken by organisations. The subject organisation has taken some steps in order to improve the structures and processes, however there is little evidence of changes in outcome, which in turn has not improved the overall perceived culture within the organisation. This would appear to continue to suspect that nurses will be pursued and blamed for untoward clinical incidents. In order to achieve the changes required there is a need to utilise the current literature in relation to the theory of error; the apportioning of blame; the need to disseminate the lessons learned from incidents and to emulate those industries successful in implementing effective reporting mechanisms.

ADDITIONAL RESEARCH.

It is suggested that further research could be undertaken as outlined in the original aims of this project i.e. involving more than a single subject organisation. This would allow not only a comparative study to be completed but also to widen the range of individual nurses who may have been prepared to take part in the study. Whilst it is acknowledged that there is nothing to suggest that the individual nurses and the organisation involved within this study were atypical, this could be affirmed through further research studies examining the same subject matter.

One of the key issues that emerged during the study was the contrasting approach adopted by different clinical disciplines in the management of incidents, in particular the difference between doctors and nurses. This was reinforced by comments made by doctors to the researcher during discussions usually following a general enquiry as to the nature of the research. It is therefore suggested that a further study could be undertaken to examine the nature of such differences and indeed to establish whether this perception could be proven through empirical data.

Having developed a model for the management of clinical incidents some further research would be beneficial to evaluate its effectiveness. In particular it would be important to examine whether the implementation of the model manages some of the issues that emerged from the data generated from the subject organisation and the interviewees. The model aims to provide a framework within which clinical incidents are managed fairly and consistently, where the true root causes can be identified and appropriately attributed and where the organisation can react to obviate the causes and to ensure learned lessons are disseminated throughout an organisation. Any analysis of the model's effectiveness should be concentrated around these aims. A further research study could potentially be a comparative study between two organisations, one using the model and another not.

FINAL WORDS

There is a great deal of rhetoric at a strategic policy level in relation to improving the NHS's management of clinical incidents. The study suggests that such initiatives are having a limited impact at an organisational level and almost no impact at an individual level. For example, the call for a blame free culture (no matter how inappropriate that may be perceived to be) is not something that is facilitated by organisations and not something which individual practitioners involved in clinical incidents have experienced in relation to nursing. Even if we accept that the terminology is inappropriate, the sentiment of adopting a system whereby incidents are reported and managed within an open and just culture, has equally failed to become part of organisational culture. Arguably this will only become part of an organisation's culture when it is compelled to adopt such an approach. One way of achieving this is through the standards set for the service. In Scotland this is through the NHS Quality Improvement Scotland's processes. At the time of the study this was through the draft clinical governance standards. Whilst it is accepted that at the time of the study they were in a draft format, there are a number of other initiatives that could have informed their development (including the predecessor CSBS standards, CNORIS standards and the NPSA systems) but these appear to have had little influence on their development. The adoption of RADAR as a model for managing clinical incidents would make a significant contribution to changing an organisational culture away from one of blame more towards one of based on justness and fairness.

Given that one of the significant deficiencies reported within the literature is a lack of a robust method of reporting and recording such incidents; it is suggested that a system, which includes all four elements of the NHS in the UK, would appear to be appropriate in order to achieve such a goal. It seems that to lose the opportunity for the relevant health departments to collaborate in managing this issue will result in a further number of years whereby the information relating to the number and type of incidents within the UK NHS remains incomplete. The solution seems relatively straightforward. The Scottish Executive should collaborate with the Department of Health in England and the NPSA to refine the work already undertaken in order to correct some of the anomalies identified

through the pilot sites and to establish a (truly) national framework for the recording, reporting and management of untoward clinical incidents.

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Fatal Accident Inquiries

Case	Judge	Date of Opinion
William Sneddon, Lemond Milroy, David Brodie McFarlane, Agnes McCoull	Sheriff K A Ross	21/1/2004
April Adam	Sheriff R E G Younger	15/12/2003
Nicola Welsh	Sheriff F R Crowe	11/12/2003
Stephen Park	Sheriff Principal R A Dunlop Q.C.	25/7/2003
Alison Aikman Duguid	Sheriff D J Cusine	8/7/2003
James Maughland	Sheriff I D Dunbar	10/3/2003
Lewis Fulton	Sheriff Principal E F Bowen Q.C.	31/1/2003
Sharman Weir	Sheriff F L Reith	23/1/2003
William George Henderson (and others)	Sheriff Principal B A Kerr	24/9/2002
Stuart Robert Hamilton	Sheriff Principal John McInnes	19/6/2002
Frances Carvill	Sheriff Principal R A Dunlop Q.C.	2/4/2002
Michelle Mcelver	Sheriff Principal R A Dunlop Q.C.	2/4/2002
Maureen Smyth	Sheriff S C Pender	26/2/2002
Joan McGlinchey	Sheriff Principal E F Bowen Q.C.	25/02/2002
Michael McTaggart	Sheriff Principal E F Bowen Q.C.	25/02/2002
Catherine Rozanski	Sheriff Principal E F Bowen Q.C.	25/02/2002
Stephen Reynolds	Sheriff Principal E F Bowen Q.C.	25/02/2002
Elaine Mullen	Sheriff Principal E F Bowen Q.C.	25/02/2002
Paul McMahon	Sheriff Principal E F Bowen Q.C.	25/02/2002
Morag Conlan	Sheriff Principal E F Bowen Q.C.	25/02/2002

Case	Judge	Date of Opinion
Andrea McQuilter	Sheriff Principal E F Bowen Q.C.	25/02/2002
Christine Jane Foster	Sheriff C N Stoddart	25/02/2002
James McNicol	Sheriff Principal E F Bowen Q.C.	25/02/2002
Sharon Jaconelli	Sheriff Principal E F Bowen Q.C.	25/02/2002
Alfred Llellywn Miller	Sheriff Principal E F Bowen Q.C.	25/02/2002
Deborah Mcelvanney	Sheriff Principal E F Bowen Q.C.	25/02/2002
Joanne Lavery	Sheriff Principal E F Bowen Q.C.	25/02/2002
Joseph Dean	Sheriff Principal E F Bowen Q.C.	25/02/2002
David Cameron	Sheriff Principal E F Bowen Q.C.	25/02/2002
Caroline Burrett	Sheriff Principal E F Bowen Q.C.	25/02/2002
Samuel Johnstone	Sheriff Principal E F Bowen Q.C.	25/02/2002
Richard King and Roland Michael Duffell	Sheriff R A Davidson	21/2/2002
William Norman Forsyth	Sheriff C G McKay	24/9/2001
Mohammaed Tasleen Iqbal	Sheriff T A K Drummond Q.C.	20/9/2001
James Fraser and Daniel Heron	Sheriff C W McFarlane	5/2/2001
Hamish Adamson	Sheriff K A Ross	19/12/2000
Darren Denholm	Sheriff N M P Morrison Q.C.	23/2/2000
Imarn Khann	Sheriff Principal E F Bowen Q.C.	20/4/1999
Amanda Duncan	Sheriff R A Davidson	10/3/1999
Gordon Scott Niven	Sheriff Principal E F Bowen Q.C.	5/3/1999

Appendix 1

Subject Letter and Information Brochure

PhD – Management of Untoward Clinical Incidents

Firstly, can I introduce myself. My name is James Miller, I have worked within the NHS for 20 years and I am currently undertaking a PhD at the University of Edinburgh. The subject area of my study is the management of untoward clinical incidents involving qualified nurses. The aim of the project is to examine how these incidents are managed and to establish whether those involved feel that the process undertaken and the outcome was 'fair'. In particular I am interested to examine the concept of blame in such situations.

I have obtained permission from the Trust to examine the management records relating to incidents and the local ethics committee has decided that ethical approval is not required for this study.

I am writing to you to ask whether you would be prepared to be involved in this research project. Your involvement in the project is entirely voluntary. If you would prefer not to be involved then I would be grateful if you could return the enclosed form, which will also help with the study.

If you would be prepared to be involved, the next stage will be a short interview with myself at a time and place, which is convenient for yourself.

There are no other researchers involved in the study and no-one from your trust will see the data collected. The detail of my supervisors is contained within the information sheet enclosed. All reports will be anonymous in the final dissertation and even the names of the Trust will not be included. Therefore, complete anonymity is assured.

I do hope you feel that you will be able to take part in this study. If so then please complete the enclosed form and return to myself. If you would like any further information or would like to clarify any issues then please do not hesitate in contacting me at any of the telephone / e mail addresses which are contained on the information sheet enclosed.

Many thanks for your anticipated assistance with this project.

Yours sincerely,

James A Miller
PhD Student

**This information sheet is designed to provide some basic details of a
current PhD study.**

**If you require any further information please do not hesitate in
contacting**

James Miller,
Divisional General Manager,
South Glasgow University Hospitals NHS Trust
0141 201 1202
E mail james.miller@sgh.scot.nhs.uk

TITLE

An Investigation into the Management and Outcome of Untoward Clinical Incidents,
Which Involve Qualified Nurses Within and Between Two National Health Service
Trusts.

INTRODUCTION

The subject area proposed for investigation is the management of clinical incidents,
which involve nurses, and in particular how outcome of the investigative process is
determined. The proposed research has both a professional nursing and a medico-legal
perspective. The wider area of study involves clinical risk management clinical
governance, which is currently exercising the minds of both managers and clinical staff
within the National Health Service (NHS).

There have been a number of studies, which have looked at the management of clinical
incidents involving medical staff but there has been little work undertaken in relation to
nursing. A number of very high profile cases, which have involved fatalities, have
resulted in considerable interest from the general public. Much of the interest is based on
who is to blame when something goes wrong within a hospital.

Questions You May Have

Why me?

A number of staff are being approached who may be prepared to discuss issues relating to the management of clinical incidents

What does it involve?

You will be asked to take part in an interview, which will be conducted by James Miller. If you agree, the interview will be recorded (audio only). The tapes and notes from the meeting will be destroyed after the study is complete.

How long will it take?

No longer than one hour.

Who will be involved?

James Miller will be the only person involved in the interview and the collation of the data. No one else has access to this information

Where and when will it take place?

At a time and place which is convenient to yourself.

Is participation voluntary?

Yes. You can withdraw from the process at any time.

Will my manager know I am taking part?

No-one will know except the researcher and anyone else you choose to tell.

Will my name appear in the report?

No. All names including that of the Trusts involved will be changed to assure anonymity.

Supervision

The researcher is supervised by Professor of Nursing Studies (Professor K Melia) and the Professor of Law (Professor R A MacCall-Smith).

Appendix 2

Consent Form

Management of Untoward Clinical Incidents

Please return this form in the envelope provided.

☐

I would like to take part in this study.

Name

☐

Address

☐

Telephone

☐

E Mail

Please identify by tick which method of contact you would prefer.

☐

I would prefer not to take part in the study.

Please provide a brief explanation for preferring not to take part.

Appendix 3

Incident Analysis Summary

Incident Evaluation Summary

The information contained in this table has been extracted from the information obtained from the documentation available for each incident.

No.	Description	Investigation Method	Follow Policy	Outcome	Classification
1	Drug Error – patient received incorrect dose of controlled drug	Disciplinary	No	Oral warning	Slip / skill based error
2	Patients given incorrect blood transfusion	Disciplinary	No	Oral and Written warning	Violation
3	Incorrect samples send to laboratory	System Review	No	Changes in procedures	Rule based error
4	Incorrect ophthalmic measurements	System Review	No	Changes in procedures	Rules based error
5	Incorrect connection of medical device	Panel review	No	Changes in procedures	Near miss
6	Complaint about staff member at cardiac arrest	Interview of staff involved	No	Actions highlighted	
7	Use of contaminated equipment	Incident review	No	Highlighting of issues	Rule based error
8	Use of contaminated equipment	Incident Review	No	Highlighting processes	Rules based error
9	Drug error- patient not given therapy for several days	Incident review	No		Rule based error
10	Drug error – patient not given therapy for 3 dyas	Incident review	No		Skill based error / lapse

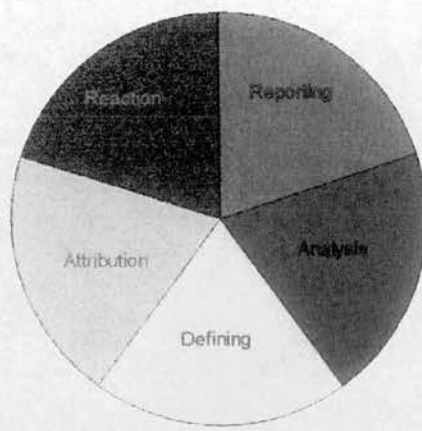
No.	Description	Investigation Method	Follow Policy	Outcome	Classification
11	Drug error -- failure to record controlled drug administration	Formal investigation	No	Education and assessment of procedure	Skill based error / lapse
12	Drug error- due to poor prescription	Formal investigation	NO		Rule based error
13	Drug error -- additional dose of drug administered	Formal investigation	No	Staff member's practice assessed	Rule based error
14	Management of cardiac arrest	Formal investigation	No	Policy and procedure changes	Skill and rule based errors
15	Patient fall	Incident recorded	No	Reminder to staff / advice to patient	Skill based error / slip
16	Patient burned	Incident recorded	No	Changes in procedure	Skill based error / slip
17	Patient fall	Incident recorded	No	Reminder to staff on procedures	Rule based error
18	Aggressive patient	Incident recorded	Yes	Patient managed	Rule based error
19	Patient fall	Incident reported	Yes	Equipment removed from use	Rule based error
20	Staff injured	Incident recorded	Yes	Staff member managed in A&E	Skill based error
21	Staff member fall	Incident recorded	Yes	Cause of slip rectified	Rule based error
22	Patient aggressive	Incident recorded	Yes	Patient managed	
23	Abusive patient	Incident recorded	Yes	Patient managed	Rule based error

No.	Description	Investigation Method	Follow Policy	Outcome	Classification
24	Staff member injured	Incident recorded	Yes	Staff managed in A&E	Rule based error
25	Aggressive patient	Incident recorded	Yes	Patient managed	
26	Drug error	Disciplinary process	No	No action	
27	Drug error – incorrect insulin dose	Disciplinary process	No	Review of procedures	Slip / skill based error
28	Drug error	Disciplinary process	No		
29	Patient found dead	Disciplinary process	No	Review of systems	
30	Drug error – patient given wrong drug	Disciplinary process	No	No action	Slip
31	Drug error – patient given incorrect drug	Self reflection	No	Staff's reflection	Skill based error / slip
31	Drug error – patient given drug at incorrect time	Investigation	No	Review of prescribing	Skill based error
32	Drug error – incorrect route of administration	Disciplinary process	No	Verbal warning	Skill based error
33	Drug error – incorrect dose	Personal report	No	None	Slip
34	Drug error – incorrect fluid administration	Incident report	No		

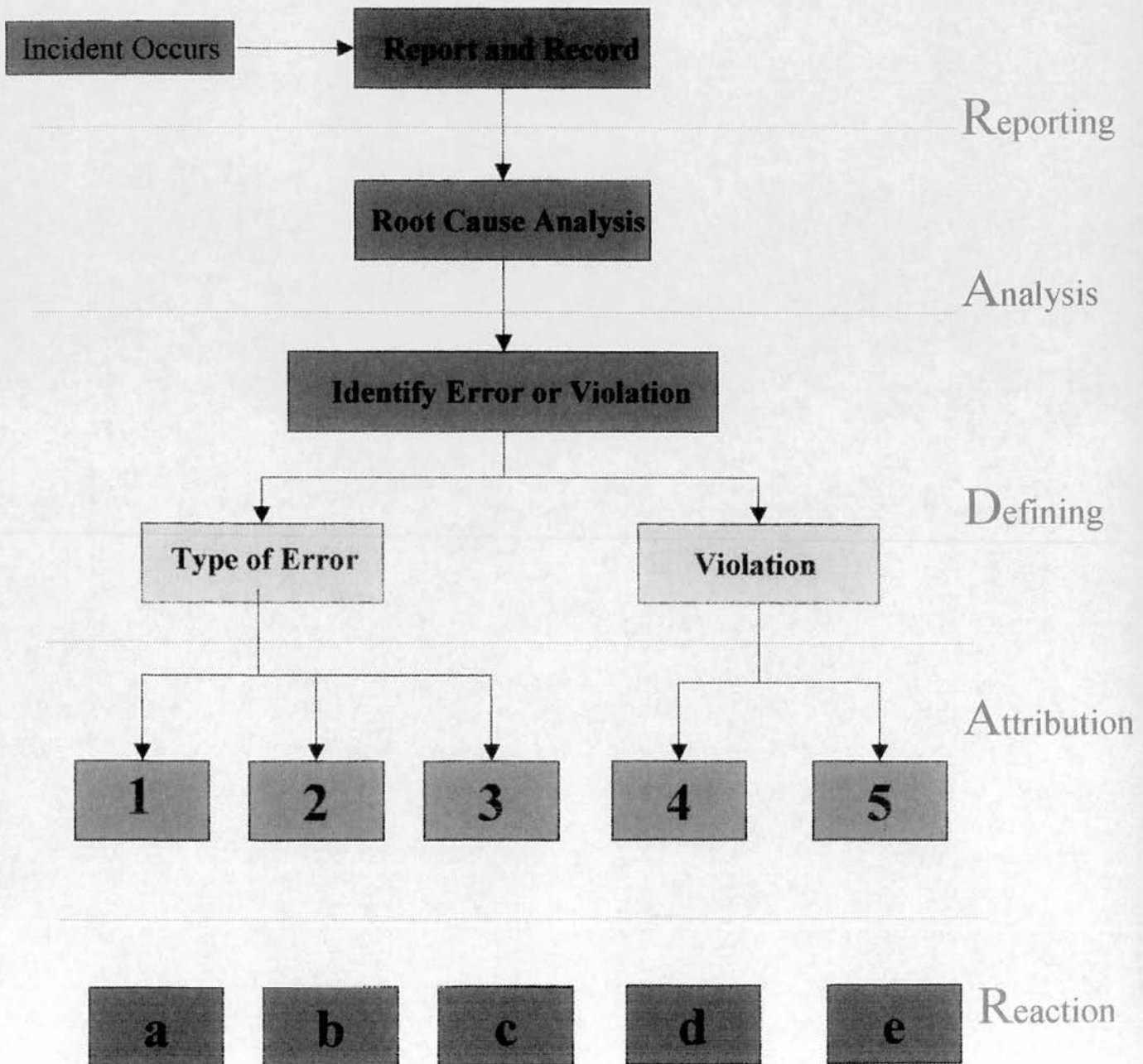
No.	Description	Investigation Method	Follow Policy	Outcome	Classification
35	Several incidents	Formal investigation	No	Several recommendations for change	
36	Alleged sexual assault	Critical incident review	No	Several recommendations for change	
37	Fire raising	Critical incident review	No	Several recommendations for change	
38	Fire	Critical incident review	No	Several recommendations for change	
39	Suicide	Critical Incident review	No	Several recommendations for change	

Appendix 4

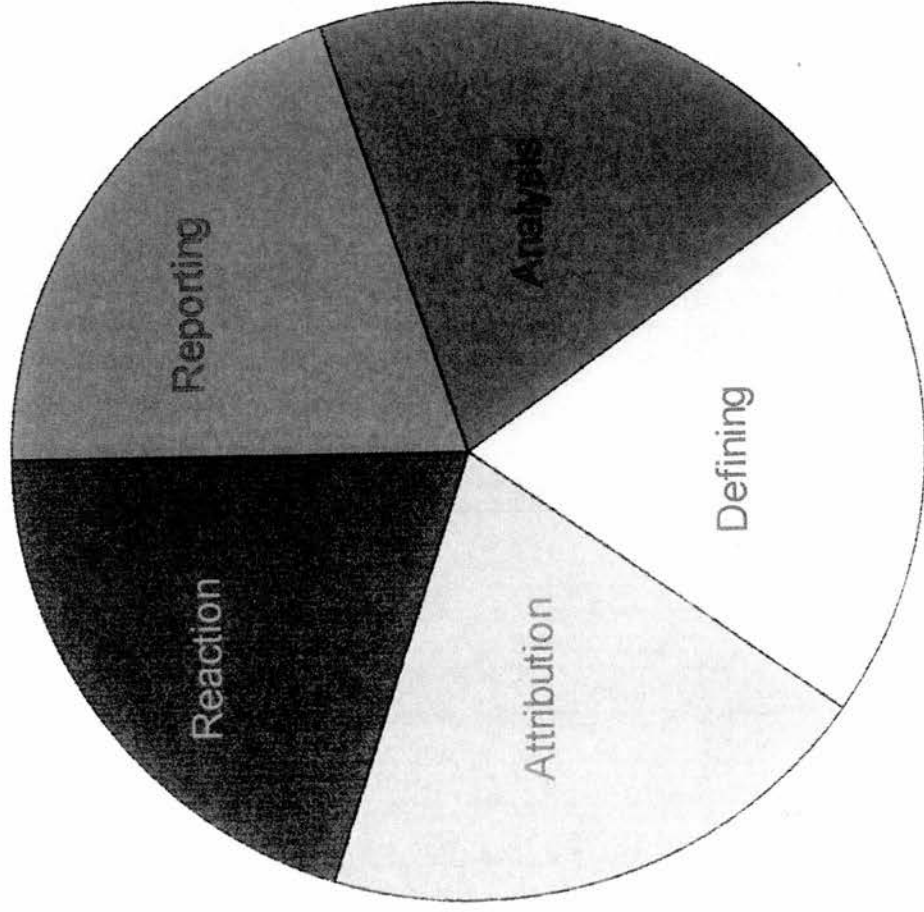
RADAR Model Summary

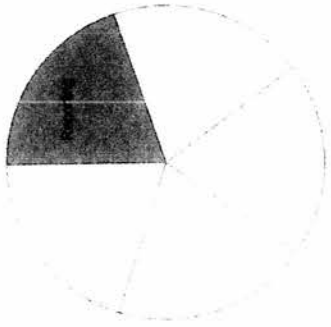


The RADAR Model for Managing Incidents



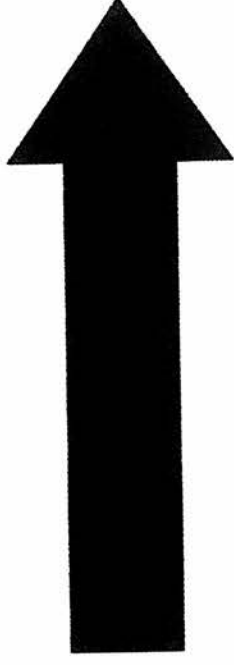
The RADAR Model for Managing Incidents

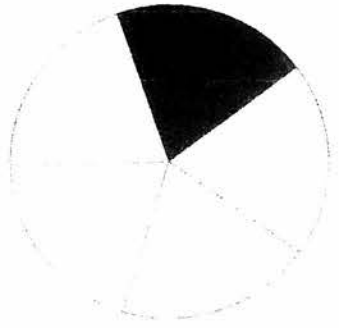




Reporting

- Reporting system should not be anonymous for incident reporting
- Reporting system should be anonymous for near misses



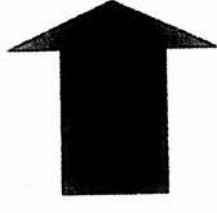
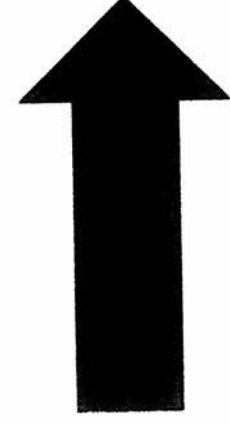


Analysis

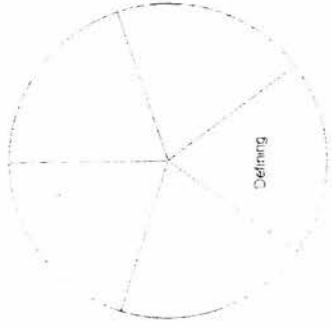
- The NPSA root cause analysis tool to analyse incidents

- Patient
- Individual staff
- Team
- Task
- Working environment
- Management and organisation
- Institutional Context

- From the cause category identify error or violation

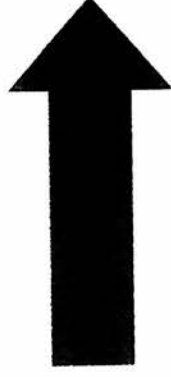


Defining



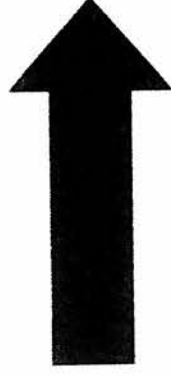
- **Error**

- Skill Based
 - Slip
 - Lapse
 - Technical
- Rule Based
- Knowledge Based
 - Knowledge Failures
 - Error of judgement








Use the root cause and error / violation to define the attribution.

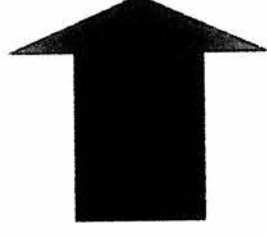
- **Violation**



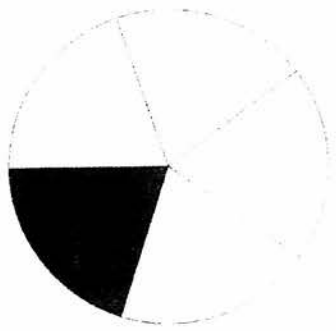


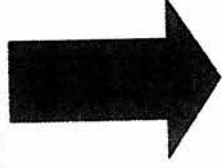
Attribution

-  1 – Attribution is to the causal effect where an individual may be the physical cause of the effect but has acted reasonably, has broken no rules and had done nothing wrong in moral terms.
-  2 – Attribution is to a failure to achieve the theoretical norm, i.e. This is a deviation from what would be described within a text book.
-  3 – Attribution is to a failure of achieve the empiric norm, I.e. This is a deviation from what would described as current practice within the field
-  4 – Attribution is a course of action knowing the existence of risk I.e. this may be described as recklessness.
-  5 – Attribution is an unambiguous intention to cause harm



Reaction

- 
- ➡ • A – A review of the organisations systems. May have implications wider than the organisation
 - ➡ • B – A review of the current literature re best practice. Additional education for staff involved
 - ➡ • C – A Review of current practice. Additional Education / supervision for staff involved
 - ➡ • D – A review of individual's actions – may be an issue of conduct or an issue of capability
 - ➡ • E – A review of individual's conduct and refer to appropriate authorities.



The outcome of all reactions must be fed-back through the organisation's clinical governance mechanism to ensure lessons are learned. Information identifying individuals should be remove in order to maintain confidentiality